CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

EP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.	—	YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber, M.D. Title: Commissioner of Health — Date: 3/28/63

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS:

C P Force — Records Management Officer — Date: 3/29/63

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

626976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

626976 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Park Ave.
(c) Hospital or institution: Mrs. Wheeler's Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Park Ave. Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence A. Hammond

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1868

8. AGE: Years	Months	Days	If less than one day
76	8	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Rev. Wm. S. Hammond D.D.
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A. Thomas
15. Birthplace Md.

16 (a) Informant Rev. Edgar T. Read
(b) Address 612 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Funeral Inc
(b) Address 1900 Eutaw Place
(By whom registrar) (b) Huntington Williams, M.D. Registrar

19 (a) 1945 18

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Augt 1944 to March 17 1945 and that I last saw her alive on March 16 1945

Immediate cause of death	Duration
Myocarditis	
Due to Bright's Disease	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno Delany Thomas M. D.
Address 718 Med. Arts Bldg Date signed March 17/45

VS 150

G26977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G26977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 E. 20th St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 E. 20th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Harry Parr Moorehead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen Moores
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) December 4, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	3	13		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Proprietor, Moorehead
11. Industry or business Vanilla Co.

FATHER
12. Name William Moorehead
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Quincy
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen M. Moorehead
(b) Address 220 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Huntington Williams, MD (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945; at 5.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 3-17 1945, and that I last saw h~~im~~er alive on 3-16 1945

Immediate cause of death	Duration
Cerebral Arterio-Sclerosis	1/2 yr.
Due to	
Due to	
Other Conditions Coronary arterio sclerosis	2 yr

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature J. Dana Moores M. D.
Address 3105 Belair Road Date signed 3-17-45

VS 150

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G26978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

G26978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Roselle Hopewell

3 (b) If veteran, name war —

3 (c) Social Security Account No: —

4. Sex: Fe | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Hopewell (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 27, 1906

8. AGE: Years 38 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Murray

13. Birthplace Maryland

MOTHER 14. Maiden Name Julia Bailey

15. Birthplace Maryland

16 (a) Informant Joseph Hopewell

(b) Address 19 N. Gilmore St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/18/45 (month) (day) (year)

(c) Cemetery or crematory Mt Zion Cem.

Location Balto. County Md

18 (a) Funeral director Chas. D. Cooper

(b) Address 542 N. Carrollton Ave.

MAR 18 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1945 to 3-14 1945, and that I last saw her alive on 3-14 1945.

Immediate cause of death Respiratory failure — Duration

Due to Pneumococcus meningitis

Due to Pneumococcus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myron G. Seitz, M.D.

Address Sydenham Date signed 3/14/45

G26979 BALTIMORE CITY HEALTH DEPARTMENT G26979

CERTIFICATE OF DEATH 125B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 9 Calvert Sts.
(c) Hospital or institution Union Memorial Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Bolton St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Fairfax Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1943

8. AGE: Years 1 | Months 3/15 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name W. Hall Harris III

13. Birthplace Maryland

MOTHER 14. Maiden Name Louise Fairfax

15. Birthplace Virginia

16 (a) Informant Hospital Record

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 19 1945 (month) (day) (year)

(c) Cemetery or crematory Location Leesburg Va.

18 (a) Funeral director Henry W. Jenkins & Son

(b) Address McCulloh & Orchard Sts

19 (a) (Date received by registrar) (b) Huntington Wills Register, M.D.

MAR 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15, 1945 to Mar. 17 1945. and that I last saw h[illegible] alive on Mar. 17 1945.

Immediate cause of death: Cardiorespiratory failure — Duration

Due to: Toxemia

Due to: Acute Epidemic Hepatitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Melchizedek Spragins

Address U. M. H. Date signed 3-17-45

X

626980 ✓ 626980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. Be sure name and address are complete and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Sterling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-87

8. AGE: Years 63 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Silas Harden
13. Birthplace ?

MOTHER
14. Maiden Name Martha ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Balto. Co.

18 (a) Funeral director J. P. Lubeing
(b) Address 1079 Mosher St

19 1945 (Date rec'd by registrar) Huntington Williams Registrar

V-S 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1945 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15- 1945 to 3-16 1945 and that I last saw h[illegible] alive on 3-16- 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Hypertensive Cardiovascular disease	
Due to Cardiac failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23 [illegible] William J. Dixon
Address Johns Hopkins Hospital Date signed 3-16-45

X

G26981 ✓ G26981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3807 Cedardale road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Cedardale road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY V. LARKINS

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William A. Larkins

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 21, 1865

8. AGE: Years 79 | Months 11 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Lewis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie O'Leary
15. Birthplace Ireland

16 (a) Informant Mr. John Larkins
(b) Address 3807 Cedardale road

17 (a) Burial (b) Date thereof 3/19/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son, Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) MAR 19 1945 (b) [illegible] Registrar
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 1941 to Mar 16 1945, and that I last saw h[illegible] alive on 3/16 1945.

	Duration
Immediate cause of death: Chr. Cardiac Insufficiency	4 yrs
Due to: Chr. nephritis + Cystitis	
Due to: general arteriosclerosis. myocardial weakness	2 [illegible]
Due to:	
Other Conditions: aged.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Adams M. D.
Address 804 Cathedral St. Date signed 3/17/45

X

G26982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G26982

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. OA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 Portland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Kolish (KOLISH)

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	married

6 (b) Name of husband or wife John Kolish

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Not know?

8. AGE: Years	Months	Days	If less than one day
About 50			hr. min.

9. Birthplace Russian (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace Russian

MOTHER
14. Maiden Name ?
15. Birthplace Russian

16 (a) Informant John Kolish
(b) Address 636 Portland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar - 19 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stonger Run, Md. B. & O.

18 (a) Funeral director John A. Gretkiewicz Jr.
(b) Address 423 S. Paca St

19 (Date received by registrar) MAR 19 1945 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 11 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Apoplexy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. (Medical Examiner.)
Date signed March 16 1945

VS 151

G26983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/2

G26983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bernardine M. Cunningham

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-01-7601

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband Wm. Raleigh Cunningham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24th 1919

8. AGE: Years	Months	Days	If less than one day
25	6	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Glenn L. Martin

FATHER
12. Name Bernard T. Drane
13. Birthplace Md.

MOTHER
14. Maiden Name Mary M. Gossman
15. Birthplace Md.

16 (a) Informant Bernard T. Drane
(b) Address 1602 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAR 19 1945 (Date rec'd by registrar) (Huntington-Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1945; at 11 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1945 to 3-17 1945 and that I last saw her alive on 3-17 1945.

Immediate cause of death	Duration
Meningo-Encephalitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 3-17-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 626984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3922 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Dorbet

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Ga
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas C Dunbar
13. Birthplace Ga

MOTHER
14. Maiden Name Anthonna Rombie
15. Birthplace Ga

16 (a) Informant Fred Crossman
(b) Address 3922 Ridgewood Ave

17 (a) Removal (b) Date thereof 3/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Thornville
Location Thornville Ga

18 (a) Funeral director Tillman Colson
(b) Address 1217 Druid Hill Ave

19 MAR 19 1945 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1945 at 8:22 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to be death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabatini M.D.
Medical Examiner.
Date signed 3/19/45

VS 151

G26985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10-8

Registered No. G26985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 849 Harlem Ave.
(c) Hospital or institution: f
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 849 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Adrienne Winn Johnson

3 (b) If veteran, name war NS

3 (c) Social Security Account No. 213-14-3405

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Clarence Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-1922

8. AGE: Years 23 | Months 1 | Days 11 12 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Glen L. Martin

FATHER
12. Name Joseph Winn
13. Birthplace Louisianna

MOTHER
14. Maiden Name Veronica
15. Birthplace Balto. Md

16 (a) Informant Veronica Winn (M)
(b) Address 849 Harlem Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balto. Md.

18 (a) Funeral director Chas. L. Cooper
(b) Address 542 N. Carrollton Av.

MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3- 1945 to 3-15 1945 and that I last saw h[illegible] alive on 3-15 1945

Immediate cause of death Pneumonia — Duration 10 Dys

Due to Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Walters M. D.
Address 1443 E Eager Date signed 3/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

626986 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N. Central Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Charles Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Myrtle Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1901

8. AGE: Years	Months	Days	If less than one day
43	3	1	hr. min.

9. Birthplace St. Thomas, Virgin Is. (Town, county, and state)
10. Usual Occupation Chief Cook
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Myrtle Hill
(b) Address 1216 N. Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantley Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MAR 19 1945
VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16-45 19 , at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18- 1945, to 3-16- 1945, and that I last saw him alive on 3-16- 1945.

Immediate cause of death: Hypertension Cardiac Renal Failure — Duration: 7

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Aubrey Alam, M. D.
Address 312 E 23rd St Date signed 3-19-45

X

626987 ✓ 626987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4707 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4707 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Scott
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. —
4. Sex: male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Jeanette Scott
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 1867
8. AGE: Years 77 Months 6 Days If less than one day hr. min.
9. Birthplace Cross Keys Balto. Co. (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name Edward W. Scott
13. Birthplace Baltimore Co.

MOTHER
14. Maiden Name Henrietta Leakins
15. Birthplace Baltimore Co

16 (a) Informant (wife) Jeanette Scott
(b) Address 4707 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Bear Hill
Location Ruxton, Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson St

19 (a) MAR 19 1945 (Registrar's signature) Wilson Booth, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 16, 1945 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 12th 1945 to Mar 16, 1945 and that I last saw him alive on Mar 16 1945

Immediate cause of death	Duration
Arteriosclerosis	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Grant Scott M. D.
Address 354 W. Biddle St Date signed 3-18-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 626988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1737 E.Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 E.Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence Hickman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Laura V.Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.20,1849

8. AGE: Years	Months	Days	If less than one day
96	1	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Laurence Hickman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Gordon
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Pasters
(b) Address 1737 E.Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) MAR 19 1945 (b) Registrar
Date received by local registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1945, at 1.40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1945 to 3/20 1945 and that I last saw him alive on 3/16 1945.

Immediate cause of death Acute heart failure — Duration
Due to Chronic endocarditis — Duration
Due to Arteriosclerosis — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 33 Arquith St Date signed 3/17/45

G26989 ✓ G26989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Greenmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY MEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Gross Meyer
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1861

8. AGE: Years	Months	Days	If less than one day
83	4	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Owner
11. Industry or business Housefurnishings

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Marie Meyer
(b) Address 3007 E. North Avenue

17 (a) Burial ion (b) Date thereof 3 - 19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar) Registrar

MAR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1945 to March 16 1945 and that I last saw him alive on March 16 1945

Immediate cause of death Bronchio-Pneumonia — Duration 5 days.
Due to
Due to
Other Conditions Generalized arterio sclerosis — 5 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert F. Kuckuck M.D.
Address 6 E Biddle St Date signed 3/17/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 626990

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3034 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET MARY ORTMANN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Otto Rudolph Ortmann
6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 25, 1889

8. AGE: Years: 55 | Months: 9 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Donoho
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Kate Goodwin
15. Birthplace: Marvland

16 (a) Informant: Otto Ortmann (Husband)
(b) Address: 3034 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3- -45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 19 1945

VS 190

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH March 16 1945, at 4.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1941 to 3/16 1945.
And that I last saw h[illegible] alive on 4/6 1944.

Immediate cause of death: Angina Pectoris — Duration: 5 Minutes

Due to: Coronary sclerosis + vascular spasm

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harry DeCarty M. D.
Address: 37 W Preston St Date signed 3/17/45

K

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

526991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

526991 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 E. 30th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 E. 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH CLAPP

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Edward

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1860

8. AGE: Years: 84 | Months: 4 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: John C. Engelking
13. Birthplace: Germany

MOTHER
14. Maiden Name: Sophia Weller
15. Birthplace: Germany

16 (a) Informant: Mr. M. G. McQuade
(b) Address: 1724 E. 30th Street, 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1944 to Mar 15 1945 and that I last saw h[illegible] alive on Mar 15 1945

Immediate cause of death	Duration
Myocardial Insufficiency	2 wks.
Due to Pulmonary Edema	3 mos.
Due to Chronic Nephritis	2 yrs.
Due to Chronic Arterio Sclerosis	
Other Conditions Acute Cystitis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm G Peyser

Address 15 E. Melton Ave Date signed 3/16/45

VS 150

G26992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G26992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 N. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. CHARLES WILLIAM WOOD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Caroline Wood
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1866

8. AGE: Years	Months	Days	If less than one day
78	4	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Physician, Ret. 40 yrs
11. Industry or business

FATHER
12. Name Charles H. Wood
13. Birthplace Bal Maryland

MOTHER
14. Maiden Name Welthen Annie Wickens
15. Birthplace Maryland

16 (a) Informant Mrs. Caroline Wood
(b) Address 1712 N. Bond Street

17 (a) Burial (b) Date thereof 3-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date rec'd by registrar MAR 19 1945 (b) Registrar

VS 190

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH March 16 1945, 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 16 1945 and that I last saw him alive on March 15 1945

Immediate cause of death	Duration
(a) Cerebral Thrombosis	Acute
Due to (b) Chr. Hypertension &	24 yrs.
Due to (c) Chr. Arteriosclerosis	
Other Conditions Hypertension	
Pulmonary Edema	Acute

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. H. Semple M. D.
Address 700 E. Fayette St Date signed 3/16/45

626993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 N. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Lang

3 (b) If veteran, name war

3 (c) Social Security Account No. 212 07 5667

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma V. Lang nee Ridgeway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1886

8. AGE: Years	Months	Days	If less than one day
58	10	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Moeller

FATHER
12. Name Carl Lang
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Emma V. Lang,
(b) Address 504 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave.

18 (a) Funeral director Harry H. Leitzke
(b) Address 4101 Edmondson Ave.

19 (a) Date received by Registrar MAR 19 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1945, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1944 to 3/15 1945 and that I last saw h[illegible] alive on 3/14 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 day
Due to Hypertension	4 yrs
Due to Myocarditis	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Carlin M.D.
Address 2145 W Baltimore Date signed 3/16/45

G26994

469194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G26994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Spies

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-45

8. AGE: Years | Months: 1 | Days: 4 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Spies
13. Birthplace Md.

MOTHER
14. Maiden Name Ruby Wilcox
15. Birthplace Md

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3401 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) Filed (b) Huntington Williams, M.D. Registrar

MAR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March-17 1945, at 1.0 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1945 to March-17 1945, and that I last saw him alive on March-17 1945.

Immediate cause of death: Bronchopneumonia due ? to B strep
Due to: ? to pyocyanaeous
Due to: Cong. heart disease
Other Conditions: Prematurity
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John K. Bingham M. D.
Address JHH Date signed 3-19-45

MAY L. DAVIS

C-26995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

Registered No. C-26995

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton cor. Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2538 W. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary L. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-6966

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife late Benjamin N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1888

8. AGE: Years 56 | Months 6 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George
13. Birthplace Md

MOTHER
14. Maiden Name Emily O.
15. Birthplace Maryland

16 (a) Informant Mr. Benjamin Davis Jr.
(b) Address 2538 W. Baltimore 21

17 (a) Burial (b) Date thereof 3/19/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Harry A Weitzer
(b) Address 4101 Edmondson Ave

19 (a) (b) Hunting for Willis Registrar
(Date received by registrar)

MAR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1945, at 1:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1945 to 3/16 1945 and that I last saw h C alive on 3/ 1945

Immediate cause of death Respiration failure — Duration

Due to Cardiac Decompensation

Due to Hypertensive C V disease (Rheumatic)

Other Conditions Hydrothorax Bilateral

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas L. Carr Jr M. D.

Address 8 Elynes Hosp. Date signed 3/19/45

Carr

G26996

AB-92569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 M

G26996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 E. 23rd. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Horace Devine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July ?-1866

8. AGE: Years	Months	Days	If less than one day
78	8	15?	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Devine (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Millie ? (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Cemetery
Location Arlington

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15- 1945, at 4.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1945, to 3-15 1945, and that I last saw h. in alive on 3-15- 1945

Immediate cause of death: Cachexia — Duration: ?

Due to: Gastro intestinal tract malignancy — Duration: 1 yr.

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houck E. Belton M.D.
Address City Hosp. Date signed 3/16/45

G26997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G26997

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hebron & Catonsville Aves
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Montgomery Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Feidler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Anna P Feidler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1894

8. AGE: Years	Months	Days	If less than one day
50	3	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Henry Feidler
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Wiesel
15. Birthplace Md

16 (a) Informant Mrs. H. J. Feidler
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Ilchester Md

18 (a) Funeral director F. C. Higinbothom
(b) Address Ellicott City Md

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MAR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1945 to 3-17 1945 and that I last saw h— alive on 3-17 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Myocardial Infarction (Acute)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas L. Carr Jr. M.D.
Address St Agnes Hosp Date signed 3/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G26998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X V 43 D

G26998 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 Wilhelm St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural - Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James T. Becraft
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rose Becraft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1873

8. AGE: Years 71 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER 12. Name — Becraft
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Ellen Porter
15. Birthplace Md.

16 (a) Informant Mary E. Shifflett
(b) Address 1926 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. (month) (day) (year)
(c) Cemetery or crematory Parkland Methodist Cem.
Location Mt. Sykesville, Carroll Co., Md.

18 (a) Funeral director C. Harry Ebaugh
(b) Address Sykesville, Md.

19 (a) Filed Mar 19 1945 Registrar Wilhelmina M. R.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1945 to Mar 18 1945 and that I last saw h.im alive on Mar 18 1945.

	Duration
Immediate cause of death: Acute Cardiac dilatation	3 days
Due to: Cerebro-vascular disease	7
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Zimmerman M. D.
Address 768 Marshall Ave. Date signed Mar 19

G26999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /2/

Registered No. G26999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Wade ave.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME George Holman

3 (b) If veteran, name war.....

3 (c) Social Security Account No. ##

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Martha A. Holman

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18, 1871

8. AGE: Years 73 | Months 11 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B. & O. Trackman

FATHER
12. Name William H. Holman
13. Birthplace France

MOTHER
14. Maiden Name Unknown
15. Birthplace France

16 (a) Informant Robert Holman
(b) Address 34 Wade Ave., Catonsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Springfield Cemetery
Location Laykesville, Md.

18 (a) Funeral director C. Harry Weer
(b) Address Laykesville, Md. Hyattsville, Md. Williamsport, Md.

19 (a) MAR 19 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1945, at 11 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1945 to 3-17 1945, and that I last saw h.i.m alive on 3-17 1945.

Immediate cause of death: Bilateral lobular pneumonia — Duration: 2 wk.
Due to.....
Due to.....
Other Conditions: Arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)
Date of operation 3-5-45
Major findings of operation: Chr. appendicitis
of autopsy: pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Joseph Zierler, M.D.
Address 218 Eutaw Place Date signed 3/19/45

G27000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G27000 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1113 E.Preston St.

(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ***

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1113 E.Preston St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Walter S.Hanson

3 (b) If veteran, name war -----

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht.	Married

6 (b) Name of husband or wife Mary E.Hanson

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 9,1882

8. AGE: Years	Months	Days	If less than one day
62	4	7	..... hr. ..... min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation House Painter

11. Industry or business

FATHER

12. Name John Hanson

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Ernestine Saumer

15. Birthplace Balto. Md.

16 (a) Informant Mrs.Mary E.Hanson

(b) Address 1113 E.Preston St.

17. (a) Burial (b) Date thereof March 19,1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Balto. Md.

18 (a) Funeral director George W.Little

(b) Address 2700 Edmondson Ave.

19 (a) MAR 19 1945 (b) [illegible] Registrar

VS 150

correct age is especially important. If unknown, please write

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945 at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1945 to 3/16 1945, and that I last saw h[illegible] alive on 3/15 1945

Immediate cause of death Coronary Thrombosis — Duration 4 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Del Smith M. D.

Address 1223 E Monument Date signed 3/17/45

[illegible] Washington Williams

X

G27001
467581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 114D

G27001
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 231 N. Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Beulah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-22-96

8. AGE: Years	Months	Days	If less than one day
48	2	22	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Davis
13. Birthplace N. C.

MOTHER
14. Maiden Name Anna E.
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) MAR 19 1945
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March-14 1945 at 2.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-20 1945 to March 14 1945, and that I last saw him alive on March-14 1945

Immediate cause of death	Duration
Brain abscess	4 mo
Due to Lung abscess	
Due to	
Other Conditions Rt middle cerebral vessel thrombosed, urinary infection	

(Include pregnancy within 3 months of death)

Date of operation 2-7-45
Major findings of operation: Large lung abscess
of autopsy Lung & Brain abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Brunch M. D.
Address J. H. H. Date signed 3-19-45

G27002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G27002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 W. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chas Blake

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widower

6 (b) Name of husband or wife Chas. Blake
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/4/1870

8. AGE: Years	Months	Days	If less than one day
75		13	— hr. — min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Charles Blake
(b) Address 11 W. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 21 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location a. a. Co. Md

18 (a) Funeral director James A. Hayes
(b) Address 442 W. Hoel St

19 (a) MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1945, to March 17 1945, and that I last saw h alive on Mar 16 1945.

Immediate cause of death Cerebral Hemm. — Duration 9 days
Due to Hypertension
Due to
Other Conditions nil
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lincoln Shelton M.D.
Address 630 N. Fulton Ave Date signed 3/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62703 62703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure that the information you give is correct and complete. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Ailsa Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Ailsa Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.) ..... years

3 (a) FULL NAME Emma M. Rohrer (Rohrer)

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Caleb W. G. Rohrer 6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/14/67

8. AGE: Years	Months	Days	If less than one day
78	1	4	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Phillip A. Albrecht
13. Birthplace Balto. City Md.

MOTHER 14. Maiden Name Eleanora Lagenauer
15. Birthplace Balto Md.

16 (a) Informant C. W. G. Rohrer
(b) Address 2814 Ailsa Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 21 45 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Reedyaville Md.

18 (a) Funeral director Lebenbaum Funeral Home
(b) Address 7401 Belair Rd

19 (a) MAR 19 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18- 1945 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15-45 19.. to 3-18- 1945 and that I last saw her alive on 3-18- 1945.

Immediate cause of death	Duration
Acute Pulmonary edema	18 hours
Due to Chronic valvular heart disease	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shelton C. Lang, M.D
Address 2117 Belair Rd Date signed 3-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27004

JO #66899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G52004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-8-4 24 26-12
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Dilmuth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Eva (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1862

8. AGE: Years	Months	Days	If less than one day
83	-1-	15	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name William Dilmuth
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory St. Josephs Cem.
Location Balto Co. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 4401 Belair Rd.

19 (a) MAR 19 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945 at 6:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 23, 1941, to Mar. 17, 1945, and that I last saw him alive on Mar. 17, 1945.

Immediate cause of death Bronchopneumonia

Duration 5 days

Due to –

Due to

Other Conditions Carcinoma of urinary bladder ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Rustigian M. D.
Address Balto City Hosp. Date signed 3-18-45

107

G27005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 W Lombard st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 W Lombard st
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Harry Drechsler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah V. McKeever

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 19, 1859

8. AGE: Years 86 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name John H. Drechsler
13. Birthplace Germany

MOTHER
14. Maiden Name Lydia Lomb
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Sarah Drechsler
(b) Address 1204 W Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W Lombard st

MAR 19 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1945, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1944 to Mar 1 1945 and that I last saw h[illegible] alive on Mar 1 1945.

Immediate cause of death Arteris-sclerosis — Duration ?

Due to Hypertensive Cardio-Vascular Disease — Duration ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carey A. Rockey M. D.

Address 1326 W Lombard St Date signed 3/12/45

VS 150

G27006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22006 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Avenue
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Baca St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Johnson Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Child

6 (b) Name of husband or wife

6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years	Months	Days	If less than one day
3			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace S.C.

MOTHER
14. Maiden Name Johnnie Mae Harper
15. Birthplace N.C.

16 (a) Informant Johnnie Mae Johnson
(b) Address 2424 Baca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore Co

18 (a) Funeral director Jas Leo H. Holland & Co
(b) Address 1631 Druid Hill Ave

19 (a) MAR 19 1945 Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1945, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945, to 3/16 1945, and that I last saw h/it alive on 3/16 1945.

Immediate cause of death: Dehydration, exhaustion, debilitation

Due to: Post partum hemorrhage - ruptured tube - syphilis

Duration
18 mos.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Tankersley M.D.
Address Univ Hosp Date signed 3-18-45

G-27007

AB-92332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

G-27007 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Ella Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: James Bond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19- 1907

8. AGE: Years	Months	Days	If less than one day
37	11	27	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clifford Jones (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Miles (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 222 N. Schroeder St

MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15- 1945, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27- 1945, to 3-15 1945, and that I last saw her alive on 3-15- 1945.

Immediate cause of death	Duration
Amyotrophic Lateral Sclerosis	2 years
Due to	
Due to	
Other Conditions Malnutrition Emaciation (Include pregnancy within 3 months of death)	1 year
Date of operation	
Major findings of operation	
of autopsy: None	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 3-16-45

X

G27008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G27008

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 Presstman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachel Gassaway

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Andrew Gassaway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1862

8. AGE: Years 82 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Mckenzie
13. Birthplace

MOTHER 14. Maiden Name Mary Ann Pratt
15. Birthplace Balto

16 (a) Informant Lillian Jones
(b) Address 1828 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MR 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to Mar. 15 1945 and that I last saw her alive on Mar 14 1945

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. B. Howell
Address 601 N. Broadway Date signed 3/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 577

G27009 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5304 Hamilton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5421 Hamilton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINA L. BRUENING

3 (b) If veteran, name war
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. Bruening, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	8	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Loehr
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Euner
15. Birthplace Germany

16 (a) Informant Mr. Wm. Bruening
(b) Address 5304 Hamilton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director Lasonka Funeral Home
(b) Address 7401 Belair Road

19 (a) (b) Registrar
MAR 23 1945 Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th, 1945 at 4:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 17, 1945, to Mar 18 1945
and that I last saw h[illegible] alive on Mar 18 1945

Immediate cause of death Paralysis of Bowels and Bladder
Due to lower extremity possibly caused by Hemorrhage of Tumor
Due to lower spinal cord
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen Burtham M. D.
Address 3139 E. Baltimore St. Date signed 3-19-45

62010 BALTIMORE CITY HEALTH DEPARTMENT 62010

CERTIFICATE OF DEATH 94A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2837 Mandlin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 Mandlin (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J E Myers

3 (b) If veteran, name war No

3 (c) Social Security Account No. 705-03-936

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hilda M. Myers

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1888

8. AGE: Years 56 | Months 5 | Days 17 | If less than one day ....hr. ....min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business B & O R.R

FATHER 12. Name Theodore G Myers

13. Birthplace Anne Arundel Co

MOTHER 14. Maiden Name Mary L Souter

15. Birthplace Shippingsburg Pa

16 (a) Informant Hilda M. Myers

(b) Address 2837 Mandlin ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Balto City

18 (a) Funeral director C. H. Goudd Evans

(b) Address 1400 W Baltimore St

19 (a) Filed MAR 19 1945 Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ....at ....M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John L Davis M.D.
Medical Examiner.

Date signed 3/18/45

G27011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27011 Registered No. 830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 S. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Mrozinska

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Machael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Chmielewske
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Marie Beckmann
(b) Address 2048 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto Md.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by Registrar) Huntington Williams Registrar

MAR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to March 17 1945 and that I last saw her alive on March 16 1944.

Immediate cause of death Cerebral Apoplexy — Duration 24 hrs

Due to Cerebral Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas J. Douglass M. D.
Address 700 N. Eutaw Date signed 3/17/45

X Dead 9 7 Douglass

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

67012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

67012 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 N. Hilton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALVATORE BOSSI

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maria Bossi
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 27, 1878
8. AGE: Years 67 | Months 1 | Days 19 | If less than one day hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Clothing Designer
11. Industry or business --

FATHER
12. Name Eugene Bossi
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Montefusco
15. Birthplace Italy

16 (a) Informant Mr. James H. Bossi
(b) Address 3810 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 19 1945 (Date received by Registrar) Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to March 16 1945, and that I last saw him alive on March 15 1945.

	Duration
Immediate cause of death: Generalized Carcinomatosis	10 months
Due to: Carcinoma of Prostate gland	4 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 1940 - Prostatectomy
Major findings of operation: carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Truchel M.D.
M. D.
Address 2901 Eutaw Place Date signed March 16 1945

X

MARGIN RESERVED—FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27013 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3624 Belvedere Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3624 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES EDWARD BUHL

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-01-2337

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian M. Buhl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1881

8. AGE: Years 63 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tile Setter

11. Industry or business

FATHER
12. Name James Buhl
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Geraldine Turnbaugh
15. Birthplace Balto., Md.

16 (a) Informant Mr. James W. Buhl
(b) Address 3624 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

MAR 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15, 1945, at 3:30PM

21. I certify that death occurred on the date above stated: that I attended deceased from March 12 1945, to March 15 1945, and that I last saw him alive on March 12 1945.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2924 Brighton Date signed 3/19/45

For S. C. J. Fabinski, by Howard J. Swann M.D. X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27444458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5510

G27014 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2436 Brambleton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul H Olmer. (Paul Harry Olmer)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-01-6928

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edmonia M. Olmer

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 3-15-90

8. AGE: Years 54 | Months 0 | Days 1 | If less than one day: hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Weissnaher & Clothing

11. Industry or business English American Tailoring Co. Inc.

FATHER
12. Name Ignatius Olmer
13. Birthplace Germany.

MOTHER
14. Maiden Name Paulsin
15. Birthplace Germany.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1944, to March 16 1945, and that I last saw him alive on March 16 1945.

Immediate cause of death: Hemorrhage from cervical vessel — Duration: 9 yrs.

Due to: Carcinoma Thyroid

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D.B. King M. D.
Address Johns Hopkins Hosp. Date signed 3/16/45

X

G27015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G27015

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Emilie L. Torsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife C. Bernard Torsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1877

8. AGE: Years	Months	Days	If less than one day
67	6	28	hr. min.

9. Birthplace Baltimore, Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Louis Prager
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Knefely
15. Birthplace Baltimore Md.

16 (a) Informant Henry L. Ziegler
(b) Address 378 N.E. 103rd St. - Miami Shores, Fla.

17 (a) ~~Interment~~ Cremation (b) Date thereof 3/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount Cem. Loudon Park
Location ~~Baltimore~~ 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Date received by Reg. MAR 19 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1944, to March 18 1945, and that I last saw her alive on March 18 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Generalized Carcinomatosis	
Due to Arteriolonephrosclerosis	
Other Conditions Fracture left femur (pathological) Osteochondroma of femur	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Ducenny

Address Union Mem. Hosp. Date signed 3/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 627016

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore Gen. Hosp.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Roselawn St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Hammel HAMMEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Catherine Hammel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1868

8. AGE: Years	Months	Days	If less than one day
76	8	28	min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Adam Hammel
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Catherine
15. Birthplace

16 (a) Informant Mr. George F. Hammel
(b) Address 2810 Roselawn Ave.

17 (a) Burial (b) Date thereof 3-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Leonard J. Rudolph
(b) Address 5305 Harford Rd.

19 (a) 3/18/45 (b) Huntington Williams, M.D.
(Date filed by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchio-Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~[illegible]~~ contributing ☐ cause of death, fill in the following: 2/6 7 45

(a) Date of injury Dec. 24 1944 7 P M.
(b) Where did injury occur? Old Harford Rd near Harford Rd
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed March 18 1945

(OVER)

Dr. Gordy
627017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

627017 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William B. Starkloff, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5579

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Mary H. Starkloff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1883

8. AGE: Years	Months	Days	If less than one day
61	3	16	hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: Credite Collection
11. Industry or business: Gas & Electric Co.

FATHER
12. Name: William B. Starkloff
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise Stahl
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Mary H. Starkloff
(b) Address: 2110 Hamilton Avenie, 14

17 (a) Burial (b) Date thereof 3/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Moreland Park
Location: Taylor Ave.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road

19 Mch 19 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to March 18 1945; and that I last saw alive on March 18 1945.

Immediate cause of death: Coronary occlusion — Duration: 1 hour
Due to:
Due to:
Other Conditions: General Condition — this — 3 years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: none
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none

23. Signature: H. H. Gordy M.D.
Address: 5106 Harford Rd Date signed: 3/19/45

Huntington Williams, M.D.

7018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 7018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Echodale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth E. Arbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Conrad Arbin
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1860

8. AGE: Years	Months	Days	If less than one day
85	--	2	...hr. ...min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Lehneis
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Vogel
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Poole
(b) Address 3312 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 March 20 '45 (Date rec'd by registrar) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at 10 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 16 1945 to March 17 1945 and that I last saw her alive on March 5 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration: March 17 1945

Due to

Due to

Other Conditions: Chronic Nephritis (arterio Sclerosis) — a number of years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Green M.D.
Address 3009 Evergreen ave Date signed 3/19/45

X Baltimore 14 Md

VS 150

27019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 27019

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Avenue
(c) Hospital or institution:
Pineridge Convelescing Home ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Eckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary M. Eckhardt

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 31 - 1863

8. AGE: Years: 81 | Months: 10 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant: Miss Eva E. Eckhardt
(b) Address: 3201 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory: Moreland
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1945, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 3 1945 to March 17 1945, and that I last saw him alive on March 17 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage (right)	3 days
Due to: Hypertension	15 yrs
Due to: Chronic myocarditis	
Other Conditions: Left hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. V. Bartold M. D.
Address 4706 Harford Road Date signed 3/17/45

6270,20

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

6270,20

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Evergreen Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Evergreen Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Fuld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11, 1868

8. AGE: Years	Months	Days	If less than one day
77-	--	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Jacob Fuld
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Eve Abel
15. Birthplace Germany

16 (a) Informant Mrs. Louis C. Hoffman
(b) Address Glen Arm, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Co.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945; at 9 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1945, to March 17 1945, and that I last saw h[illegible] alive on March 16 1945

Immediate cause of death Right Hemiplegia (Cerebral Hemorrhage) — Duration March 10 1945

Due to

Due to

Other Conditions Arteriosclerosis — Duration Approximately 7 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green M.D.
Address 3009 Evergreen Ave Baltimore 14 Md. Date signed 3/19/45

VS 150

G27021

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 87E

G27021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin W Banner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-41

8. AGE: Years	Months	Days	If less than one day
3	6	6	hr. min.

9. Birthplace Tenn. Erwin (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Junior Banner
13. Birthplace Tenn.

MOTHER
14. Maiden Name Lola Edwards
15. Birthplace N.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) removal (b) Date thereof 3/19/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Erwin Mem. Cem.
Location Erwin, Tenn.

18 (a) Funeral director M. W. Dippel & Sons
(b) Address 1200 Park Ave

19 (a) Registered MAR 19 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18- 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1945 to 3-18 1945, and that I last saw him alive on 3-18 1945

Immediate cause of death	Duration
Increased intracranial pressure	3 days
Due to unknown etiology	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: increased intracranial pressure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W. Helfrich M. D.
Address Johns Hopkins Hospital Date signed 3-18-45

X

G27022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 Laureus St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 Laureus St (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Collier

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-4710

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. ? Widow

6 (b) Name of husband or wife Louis S. Collier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1885

8. AGE: Years 59 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Catonsville, Md. (Town, county, and state)

10. Usual Occupation Saleswoman

11. Industry or business Hutzler Brothers Co.

FATHER
12. Name James T. Warner
13. Birthplace Unknown

MOTHER
14. Maiden Name Susan Knight
15. Birthplace Unknown

16 (a) Informant Elizabeth Justis
(b) Address 3308 Burleith Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Edwards Funeral Home
(b) Address 3911 Liberty Hghts Ave.

19 (a) Date received MAR 19 1945 (b) Registered by Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Accident

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed

VS 151

G27023 MOORE G27023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 W. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 537 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	married

6 (b) Name of husband or wife J. Elmer Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1903

8. AGE: Years	Months	Days	If less than one day
41 42	5	17 20	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Williams
13. Birthplace Md

MOTHER
14. Maiden Name Nancy Batton
15. Birthplace Md Md

16 (a) Informant Mrs. Mary Douglas
(b) Address 312 N. Allington Ave.

17 (a) Burial (b) Date thereof Mar. 20 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dan Veni
Location Frederick, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address N. Schroeder St.

MAR 19 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1945, to Mar 16 1945 and that I last saw h[illegible] alive on Mar 16 1945.

Immediate cause of death Cancer of Liver

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Months Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Pelletheim M. D.
Address 517 Hamilton Ter Date signed Mar 19/45

X

G27024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1834

G27024
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd
(c) Hospital or institution Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Byrd Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jos. W. Taylor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 21 1864

8. AGE: Years	Months	Days	If less than one day
80	5	28	hr. min.

9. Birthplace Mears, Accomac Co., Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	MOTHER
12. Name George Byrd	14. Maiden Name Elizabeth Parks
13. Birthplace Mears Accomac Co. Va.	15. Birthplace Mears Accomac Co. Va.

16 (a) Informant Mr. Reginald W. Taylor (Son)
(b) Address 3927 Belvieu Ave. City
17 (a) Burial (b) Date thereof 3-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Protons Cemetery
Location Hallwood, Accomac Co. Va.
18 (a) Funeral director STEWART & MOWEN COMPANY
(W. F. WOODEN SUC.) 106 W. NORTH AVENUE
(b) Address
19 (a) Date received by registrar MAR 19 1945 (b) Huntingtown Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 1945 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944 to March 19 1945 and that I last saw him alive on March 19 1945.

Immediate cause of death Uncorrected hemorrhage — Duration 3 mos.
Due to
Due to
Other Conditions Cerebral Hemorrhage — 8 mos.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Nelson M. D.
Address 3 W. Lib[illegible] Date signed 3-19-45

G27025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117 B

G27025 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Washburn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Washburn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Everett Irving W. Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alma Sundstrom
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1888

8. AGE: Years	Months	Days	If less than one day
56	6	21	24 hr. min.

9. Birthplace Cushnut, Mass (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER 12. Name Everett E. Chase
13. Birthplace Mass.

MOTHER 14. Maiden Name Annie Ferris
15. Birthplace Mass.

16 (a) Informant John Webster
(b) Address 3912 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month), (day), (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John T. Devers Inc.
(b) Address 75 Light St Baltimore, Md

19 (a) MAR 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945 at 3.32 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1945 to 3/18 1945 and that I last saw h[illegible] alive on 3/18 1945

Immediate cause of death	Duration
[illegible] Collapse	
Due to Hemorrhage	
Due to Duodenal Ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Duodenal Ulcer Perforated
of autopsy: Bleeding Peptic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren A. Walker M.D.
Address 4400 N. Charles Date signed 3/19/45

X

VS 150

627026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945 Registered No. 627026

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Folsom St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Folsom St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida D. Vogelman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles W. Vogelman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 20, 1878
8. AGE: Years 66 | Months 2 | Days 27 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Augustus Klages
13. Birthplace Europe

MOTHER
14. Maiden Name Ellen Myers
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Evelyn Andrae
(b) Address 4220 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave
18 (a) Funeral director John F Kenny Inc
(b) Address 715 Eight St
19 (a) Filed MAR 21 1945 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1945 at M

21. I certify that death occurred on the date above stated that I attended deceased from Jan 10 1945 to March 17 1945, and that I last saw her alive on March 17 1945

Immediate cause of death: Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions: Arteriosclerosis, Hypertension, Cystectomy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Schwamb M. D.
Address 1307 S. Clinton Date signed 3/20/45

VS 150

X

B 27027 470256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

Registered No. B 27027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison, Md
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Madison
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Insley.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-86

8. AGE: Years	Months	Days	If less than one day
58	9	3	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation machinist.
11. Industry or business

FATHER 12. Name Perrin L. Insley
13. Birthplace Md.

MOTHER 14. Maiden Name Rachel Moore
15. Birthplace Md

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Middletown M E Church
Location Eastern Shore Md
18 (a) Funeral director John T Kenny
(b) Address Lloyd & Montgomery
19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945 at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1945 to March 15 1945 and that I last saw him alive on March 15 1945

Immediate cause of death (Primary) Cerebral Hemorrhage
Cerebral Hemorrhage
Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3/12/45
Major findings of operation: Primary tumor — Left frontal hemisphere.
of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo W. Crawford M. D.
Address Johns Hopkins Hosp Balto Md. Date signed 3/19/45

VS 150

G27028 — BALTIMORE CITY HEALTH DEPARTMENT — G27028 — Registered No. .....

CERTIFICATE OF DEATH 13 a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 No Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 No Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin J. Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day ... a. hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER 12. Name Abraham Green
13. Birthplace England

MOTHER 14. Maiden Name Cole
15. Birthplace New York

16 (a) Informant Abraham Green
(b) Address 921 No Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Lorsdale
Location Philg Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150 MAR 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18- 1945, at 3 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to 3/18 1945 and that I last saw him alive on 3-17 19 45

Immediate cause of death Uremia — Duration 1 year

Due to Chronic Nephritis — 3-5 years
Hypertension

Due to Cardiac Hypertrophy — 3-5 years
& Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shyden Cooper M. D.
Address 2201 Eutaw Place Date signed 3/19/45

X

627029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/31a Registered No. 627029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 VIOLET AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 VIOLET AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE RAITZYK - ALSO REISIG.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife MEYER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name SAMUEL KATZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name HANNAH
15. Birthplace GERMANY

16 (a) Informant MRS. L. J. BARR
(b) Address NORFOLK VA.

17 (a) BURIAL (b) Date thereof 3-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTO HEBREW
Location BELAIR RD.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO Huntington Williams, M.D.

19 (a) MAR 19 1945 (b) —
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-45 19... at 10.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6, 1941 to Mar. 18 1945, and that I last saw her alive on 3/18 1945

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Renal Disease	2
Due to	
Due to	
Other Conditions	2 wks

Uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 206 E. Preston St. Date signed 3/19/45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27030 / 50 — Registered No. 5640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Yetta Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Carlisle Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Abraham Abramson
13. Birthplace Russia

MOTHER
14. Maiden Name Irene
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Cem. Pa.
Location Jack Levy Inc
18 (a) Funeral director 1432 E. Baltimore St.
(b) Address
19 (a) MAR 20 1945 (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

SS

20. DATE OF DEATH 3-19-45 19 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8, 1942 to March 19 1945. and that I last saw he alive on March 19 1945.

Immediate cause of death: Metastases due to breast carcinoma. — Duration: about 2½ yrs.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel Shpritz, M.D. M. D.

Address 1810 Eutaw Pl. Date signed 3/19/45.

X

2875 [redacted] G27031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13/a G27031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 938 MONTPELIER ST.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 MONTPELIER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY E. FUNK

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife CORNELIA FUNK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 16 1867

8. AGE: Years 77 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation STA. ENGINEER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO.

16 (a) Informant ETHEL FUNK (DAUGHTER)
(b) Address 1915 RIGGS AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 20/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeh Co
(b) Address 403 S. WOLFE ST. Balto. Md.

19 (a) (Date rec'd by registrar) MAR 19 1945 (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 17 1945; at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1945, to March 17 1945, and that I last saw her alive on March 16 1945.

Immediate cause of death	Duration
Broncho Pneumonia	2 days
Due to Malignant Regurgitation Stenosis	7 days
Due to Hypertension Arterio Sclerosis	7 d. 7 d
Other Conditions Chr. Interstitial Nephritis	7 d.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. A. Stevens M. D.

Address 2878 Hartford Ave Date signed 3-17-45

920

G27032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G27032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richwood & Evans
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 St Johns Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Figgs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Frank Figgs
13. Birthplace

MOTHER
14. Maiden Name Rosalie Martin
15. Birthplace Henderson, N.C.

16 (a) Informant Frank Figgs
(b) Address 726 St Johns Rd, Balt Md

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAR 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 19 1945 Huntington Williams, M.D. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1945, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 3/11 1945, and that I last saw her alive on 3/11 1945

Immediate cause of death Prematurity, atelectasis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Marks M. D.
Address Univ Hosp. Date signed 3/11/45

2588

G27033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G27033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Hollins St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hays

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James W. Hays

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25. 1861

8. AGE: Years 83 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Shannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Larkins
15. Birthplace Ireland

16 (a) Informant Geo Hays
(b) Address 1703 Hollins St

17 (a) Burial (Burial, cremation, or removal?) (b) Date thereof 3/20/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Aldersgate ave

18 (a) Funeral director Hollis & Ellmore
(b) Address Hollins & Ellmore

19 (a) (Date received by registrar) Huntington Williams Md Registrar

MAR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at 3.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to March 16 1945 and that I last saw her alive on March 16 1945

Immediate cause of death

	Duration
Acute cardiac dilatation	2 days
Due to Chronic myocarditis	10 yrs
" Hypertension	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Calos M. D.

Address 47 N. Fulton Ave Date signed

G27034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27034

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Orleans St
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Minnie Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1868

8. AGE: Years 76 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Balto Transit Co

11. Industry or business

FATHER
12. Name James M Johnson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Susan Chambers
15. Birthplace Baltimore

16 (a) Informant James M Johnson
(b) Address 1922 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1945, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 11 1945 to Mar. 17 1945 and that I last saw h. INI alive on Mar. 16 1945

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Chronic Nephritis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Joseph Lankey M. D.
Address 444 N. Ellwood Ave. Date signed 3/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G47035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G47035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Orleans St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Orleans St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE O'CONNOR LIPPLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anthony Lipple

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) April 2, 1891

8. AGE: Years 53 | Months 11 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Dubois, Penna.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosanna Rice
15. Birthplace Ireband

16 (a) Informant Anthony Lipple
(b) Address 2106 Orleans St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 MAR 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945 19 ____, at 4:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1943 to Mar 16 1945.
and that I last saw h— alive on Mar. 14 1945.

Immediate cause of death: Myocardial Infarction — Duration: 3 days

Due to: Generalized arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F Coolahan M. D.
Address 24 W. Fenhan Ave Date signed 3/17/45

VS 190

G27036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G27036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution: Ashburton Nursaing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Carbone

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Vincent Carbone
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1866

8. AGE: Years	Months	Days	If less than one day
79.	2	17.	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Salvatorio Pistorio
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Louis Carbone (Son)
(b) Address 1519 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto; Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 MAR 19 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944, to Feb 17 1945, and that I last saw h.m alive on Feb 17 1945.

Immediate cause of death	Duration
Carcinoma of Sigmoid	
Due to	
Due to	
Other Conditions Metastasis and anaemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. Kadin M. D.
Address 2306 Eutaw Pl Date signed 3-19-45

G27037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27037 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland Ave.
(c) Hospital or institution: West Balt Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 Maple Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORMAN McCALL

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-6290

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 24-1909

8. AGE: Years 35 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Agric Inspector

11. Industry or business Veterinary Medical Service

FATHER 12. Name William A. McCall

13. Birthplace Va

MOTHER 14. Maiden Name Sarah J. Foster

15. Birthplace Va

16 (a) Informant William A. McCall

(b) Address 1328 Maple Ave Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20-45
(month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md

18 (a) Funeral director J. H. Wisner-Sons

(b) Address 657 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1945 at 4A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1945 to 3/17 1945
and that I last saw h. alive on 3/17 1945

Immediate cause of death Coronary thrombosis with ventricular tachycardia.

Due to

Due to

Other Conditions Pulmonary infarction
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Schenfeld M.D.

Address West Balt. Gen. Hosp. Date signed 3/17/45

vs MAR 19 1945

G27038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D (Grant) G27038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Grantley Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9/12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Grantley Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine J. Vogel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Geo. C. Vogel.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1st 1874

8. AGE: Years 70 | Months 9 | Days 14 | If less than one day hr. 16 min.

9. Birthplace Germany Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name J. F. Suresch (Suresch)
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Eppley
15. Birthplace Germany

16 (a) Informant Grace Vogel
(b) Address 3607 Grantley Rd

17 (a) Burial (b) Date thereof Mar 20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore md

18 (a) Funeral director F. D. Kilpatrick Son
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180 MAR 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1945 at 11 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1945, to 3/17 1945, and that I last saw her alive on 3/16 1945.

Immediate cause of death
1) Arteriosclerotic Heart Disease — Duration 5 yrs. ?
Due to
Due to
Other Conditions - Generalized Sclerosis (Include pregnancy within 3 months of death) — 5 yrs.

Date of operation —
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Date signed 3/19/45

X

G27039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G27039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 9W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 E Federal St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Breckenridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna Breckenridge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1872

8. AGE: Years 72 | Months 3. | Days 25 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Samuel Breckenridge

13. Birthplace Va.

MOTHER 14. Maiden name Nancy Wildman

15. Birthplace Va.

16 (a) Informant Anna Breckenridge

(b) Address 1311 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location 2 North Avenue

18 (a) Funeral director Wendell F. Humphreys

(b) Address 1501 N. Broadway

19 (a) (Date received by registrar) (b) Registrar

MAR 19 1945

Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 19 45 at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 19 45 to 3/17 19 45 and that I last saw h/ alive on 3/17 19 45.

Immediate cause of death Bronchopneumonia Duration

r.b. lung.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Carl Myers

Address Franklin Sq. Hosp. (Date signed M. 3 D. 17 45)

X

G27040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 477

G27040 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County A
(c) City or town Ft. Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 4319 17th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Drayton Pope

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine S. Pope

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 6-21-84

8. AGE: Years 60 | Months 8 | Days 26 | If less than one day: hr. min.

9. Birthplace Columbia S.C. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Ry.

FATHER
12. Name John Pope
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Drayton Pope
15. Birthplace S.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Park Cem.
Location Baltimore Md.

18 (a) Funeral director E. Miller Langrall
(b) Address 4810 Liberty Heights Ave

19 (a) 3-19-1945 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 11:47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 9 1945 to Mar 17 1945 and that I last saw him alive on Mar 17 1945

Immediate cause of death Suffocation due to bronchial secretions & Carcinoma — Duration

Due to Post operatively to left pneumonectomy

Due to Carcinoma Left lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-16-45

Major findings of operation: Carcinoma left bronchus

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. Handelman M.D.

Address 4414 Date signed 3-19-45

627041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 627041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3027 Oakley ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 Oakley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard J. Stein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna Stein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/1870

8. AGE: Years	Months	Days	If less than one day
75	1	27	hr. min.

9. Birthplace Jany 22 - 1870 (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name Johann Stein
13. Birthplace Germany

MOTHER
14. Maiden Name Englert
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave

18 (a) Funeral director Frank H. Yeurel
(b) Address Pikesville, Md.

19 MAR 20 1945 (Date rec'd by registrar) Huntingtown Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1945 at 4:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio - Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer J Wallen M.D.
Medical Examiner.
Date signed 3-19-45

VS 151

G27042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4706 Gelston Drive
(c) Hospital or institution: Sinai Hospital — Admitted from Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Randle

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1883
8. AGE: Years 62 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business

FATHER
12. Name Joseph E. Randle
13. Birthplace Baltimore Co. Md

MOTHER
14. Maiden Name Margaret A. Randle
15. Birthplace Baltimore Co. Md.

16 (a) Informant Wm W. Hobbs
(b) Address 4706 Gelston Drive

17 (a) Burial (burial, cremation or removal) (b) Date thereof March 22-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Frank A. Purnell
(b) Address Princess Anne, Maryland

MAR 24 1945 (Date rec'd by registrar) Huntingtown, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1945, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/ 1945 to 3/19 1945, and that I last saw h[er] alive on 3/19 1945

Immediate cause of death	Duration
Cardio Resp Failure	
Due to Coronary Thrombosis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Simpson, M. D.
Address Sinai Hospital Date signed 3/19/45

G27043 EMMA DORSEY ✓ G27043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Pierce
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto md (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Pierce (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Dorsey ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 7-4-1905

8. AGE: Years 39 | Months 8 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Frank Dorsey

(b) Address 727. Pierce st

17 (a) Burial (b) Date thereof 3 23-45 (month) (day) (year)
(burial, cremation, or removal)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Leonard O'Whalen

(b) Address 918 N. Pine st

19 (a) (b) Registrar

MAR 20 1945 Lafayette Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1945 to March 18 1945. and that I last saw h.. alive on March 18 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address 715 [illegible] Date signed 3/19/45

G27044 470348.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G27044 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Jackson Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Segal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-10

8. AGE: Years 34 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Storekeeper.

11. Industry or business

FATHER 12. Name Eli Segal
13. Birthplace Ky.

MOTHER 14. Maiden Name Jennie Glassman
15. Birthplace Ky.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location

18 (a) Funeral director Jack Levin Ind
(b) Address 1439 E. Balto. St

MAR 20 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March-19 1945, at 8.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March-11 1945 to March-19 1945 and that I last saw him alive on March-19 1945.

Immediate cause of death	Duration
Cardiac failure	20 months
Due to Hypertensive & Arteriosclerotic Heart Disease	
Due to Renal Arteriosclerosis	
Other Conditions Prostatectomy Nodosa	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Cardiac hypertrophy Chronic Glomerulonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac E. Murphy M.D.
Address X Johns Hopkins Hosp. Date signed 3/20/45

G27045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27045

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Annesley Rd Dundalk
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rebecca Betty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Samuel F. Betty
6 (c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) July 1, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	18	hr. min.

9. Birthplace Delaware
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William Watterton
13. Birthplace Canada

MOTHER
14. Maiden Name Margaret Wilson
15. Birthplace Ireland

16 (a) Informant Mr. Clifford Betty (son)
(b) Address 3 Annesley Rd Dundalk

17 (a) Removal (b) Date thereof 3/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington Del.

18 (a) Funeral director Wellach J. Dickerson Sons
(b) Address North & Pendleton Sts

19 (a) MAR 20 1945 (b) Huntington Williams M.D.
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1945 to 3-19 1945, and that I last saw h ex alive on 3-19 1945

Immediate cause of death	Duration
Cerebrovascular hemorrhage	2 mos
Due to Hypertensive cardiovascular disease	yrs
Due to	
Other Conditions Essential cystitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Marvin W. Davis M. D.
Address Church Home Date signed 3-19-45

627046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 627046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 Marydale ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4738 Frederick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Clyde Gray

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-3087

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Lenore Gordon Gray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1884

8. AGE: Years	Months	Days	If less than one day
60	7	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business B. & O. R. R.

FATHER
12. Name Robert C. Gray
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Selby
15. Birthplace Snow Hill, Md.

16 (a) Informant Mrs. Myrtle V. Loetz
(b) Address 4738 Frederick Ave.

17 (a) Burial (b) Date thereof 3/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1945; at 9 50 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-19-45

VS 151

627047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627047 Registered No.

PLEASE WRITE PLAINLY—WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Annapolis Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - Highlands
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Vermont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Lee Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No. - -

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1938

8. AGE: Years: 6 | Months: 7 | Days: 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vernon Lee Dorsey
13. Birthplace Portsmouth Va.

MOTHER
14. Maiden Name Elsie M. Ahlfeldt
15. Birthplace Baltimore Maryland

16 (a) Informant Mr. Vernon L. Dorsey
(b) Address 2911 Vermont Ave., Balto.

17 (a) Burial (b) Date thereof 3/21/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location Wash. Blvd., Dorsey Md.

18 (a) Funeral director Wm. J. Pickett & Sons
(b) Address Balto., Md.

19 (a) MAR 20 1945 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945, at 8 50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection, Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Aorta

Due to Mycotic aneurysm

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 18 1945

X Aneurysm

G27048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G27048 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 E. 25th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice Kent Lau

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Millard F. Lau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/9/1884

8. AGE: Years	Months	Days	If less than one day
60	8	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or Business

FATHER
12. Name Oliver Carroll Bushman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Fannie Gaither
15. Birthplace Balto., Md.

16 (a) Informant Mr. Millard F. Lau
(b) Address 418 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

MAR 20 1945

19 (a) (Date rec'd by registrar) (b) Huntington White, Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1945 at 7A M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D. Medical Examiner.
Date signed March 19, 1945

VS 151

G27049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

G27049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St -
(c) Hospital or institution:
Home for Incurables - 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Flack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow -

6 (b) Name of husband or wife: Louis Henry Flack (deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 - 1856

8. AGE: Years 88 | Months 8 | Days 22 | If less than one day ....hr. ....min.

9. Birthplace Alexandria - Va.
(Town, county, and state)

10. Usual Occupation House wife -

11. Industry or business

FATHER 12. Name David Applich -

13. Birthplace Germany -

MOTHER 14. Maiden Name Caroline Basch -

15. Birthplace Berlin - Germany

16 (a) Informant H. L. Browning

(b) Address 700 W. 40th St (Home)

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3 (month) 21 (day) 45 (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address MAR 20 1945 Md.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 7:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938 to March 18 1945, and that I last saw her alive on March 17 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	37 hours
Due to: Hypertension and Arteriosclerotic Cardiac Vascular Renal	10 years
Due to	
Other Conditions: Hypertrophic Arthritis	10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.

Address 11 E. Chase St. Baltimore (3) Md. Date signed 3/18/1945

627050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 627050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK V. RHODES

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Caroline Taveau Rhodes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1855

8. AGE: Years 89 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation Retired Lawyer

11. Industry or business

FATHER
12. Name George
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Cunningham
15. Birthplace -

16 (a) Informant Mr. Andrew J. Young, Jr.
(b) Address Box 122, Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945 at 4:30 a M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 20 1944 to Mch 18 1945 and that I last saw h[illegible] alive on Mch 18 1945.

Immediate cause of death: Paralysis — Duration: 3 months

Due to:

Due to:

Other Conditions: Prebral Hem with Mthage
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Lee Rhodes Jr. M.D.
Address 112 W. 20th St. Date signed Mch 19, 45

PHYSICIAN
Underline the cause to which death should be charged statistically.

G27051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 3B

G27051
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITER, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cheapside
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME (Wesley) Herman Franklin Ferrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-17-9150

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-16, 1909

8. AGE: Years	Months	Days	If less than one day
36	2	1	hr. min.

9. Birthplace Waena, Georgia
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name John Frank Ferrell
13. Birthplace Unknown

MOTHER
14. Maiden Name Lella Gullman
15. Birthplace

16 (a) Informant R.E. Elliott & Son
(b) Address Augusta, Georgia

17 (a) Removal (b) Date thereof 3-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West View Cem.
Location Augusta, Georgia

18 (a) Funeral director Myers Bros.
(b) Address 5005 Park Heights Ave

19 (a) MAR 20 1945 Huntington Williamsburg, Md.
(Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945; at 9:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Frater M.D.
Medical Examiner.
Date signed 3-17-45

G27052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G27052 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INDELIBLE PENCIL, NOT FADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 E Lee St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Wilhelm

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Fannie Wilhelm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	29	hr. min.

9. Birthplace Smyrna Del
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Arundel Sand & Gravel Co

FATHER
12. Name Dan Brown
13. Birthplace Ire

MOTHER
14. Maiden Name Unk
15. Birthplace Ire

16 (a) Informant John Lamartina
(b) Address 403 Patapsco Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location York Pa

18 (a) Funeral director A Howard Evans
(b) Address 1400 St Charles St

19 (a) MAR 20 1945 (Date received by Registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1945; at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-17-45 at 25|6 P. M.
(b) Where did injury occur? City Harbor, foot of Frankford Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Recovered from the City Harbor

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-19-45

VS 151

Interior Williams M.D.

G27053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27053 Registered No.

JO #77894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 4mos. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adlena Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1922

8. AGE: Years	Months	Days	If less than one day
22	-4-	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Leonard Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Brown
15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory
Location Westchelly Va.

18 (a) Funeral director Chas. H. Alexander
(b) Address 922 N. Mountford

19 (a) MAR 20 1945 (Date rec'd by registrar) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1942, to Mar. 17, 1945, and that I last saw h.. alive on Mar. 17, 1945.

Immediate cause of death: Generalized Amyloidosis — Duration (1)
Due to: Tuberculosis
Due to: Pulmonary Tuberculosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md Date signed 3-19-45

G27054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Peter John Thomas~~ Thomas (Thomas Thomas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~ John B. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1874

8. AGE: Years 70 | Months 4 | Days 29 | If less than one day ....hr. ....min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Joseph Frietsch
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant John B. Thomas
(b) Address 1927 St. Paul St - 2nd Floor

17 (a) Burial (b) Date thereof 3/22/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or Crematory~~ Balto
Location Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 MAR 20 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1945 to 3/19 1945, and that I last saw h.. alive on 3/19 1945.

Immediate cause of death	Duration
Respiration failure	
Due to Central Hemorrhage	
Due to Hypertension Cardio-Vascular Dis. (1943)	
Other Conditions Uremia + Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh E. Carr Jr. M.D.
Address St. Agnes Hosp. Date signed 3/19/45

VS 150

627055

TN. 63476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 627055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 6- 23

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5412 Knell Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Melvin Sellers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Sept.

6 (b) Name of husband or wife Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4th, 1898

8. AGE: Years	Months	Days	If less than one day
46	7	15	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Sellers

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Florence Thompson

MOTHER 15. Birthplace Marylans

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)

(c) Cemetery or crematory Johnnie

Location Forkville Md Co Inc

18 (a) Funeral director Wilson & Son

(b) Address 217 E Pratt St.

19 (a) MAR 20 1945 (b) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th, 1945, at 8.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26-43 19 to 3-19-45 19, and that I last saw him alive on 3-19-45 19.

Immediate cause of death	Duration
Pulmonary Hemorrhage	2 wks.
Due to Pulmonary tuberculosis bilateral	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harold Gilton M. D.

Address Balto City Hosp. Date signed 3/19/45

627056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 627056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Adams

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of ~~husband or~~ wife Ola Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1876

8. AGE: Years 68 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Rarden Ohio
(Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Curtis Bay Ship Yards

FATHER
12. Name Henry Adams
13. Birthplace Rarden, Ohio

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Frida Holbrook
(b) Address Severna Park Md.

17 (a) Removal (b) Date thereof 3/20/45
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Joy
Location Rarden Ohio

18 (a) Funeral director W. T. Cook Inc
(b) Address 1253 E. Paul St.

19 (Date rec'd by registrar) MAR 20 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-45 19 , at 11:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15-45 19 to 3-18-45 19 , and that I last saw h.i.h. alive on 3-18-45 19

	Duration
Immediate cause of death Pulmonary infarct	
Due to marked thrombosis → embolus	
Due to Cardiac decompensation	6 months
Other Conditions Hypertension Pulmonary stasis	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Confirmed the findings, except

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerry Patterson M. D.

Address University Hosp. Date signed 3/19/45

G27057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27057 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 441 N. Bouldin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 441 N. Bouldin St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Nolan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Jane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Patrick Nolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Margaret Harrison
(b) Address 441 N. Bouldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Shrewsbury Penna

18 (a) Funeral director John A. Hagan
(b) Address 300 E. Baltimore St

19 (a) MAR 20 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1945, to Mar 19 1945, and that I last saw h[illegible] alive on March 19 1945

Immediate cause of death Coronary Thrombosis — Duration 6 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burton L. Solomon M.D.

Address 179 S. Broadway Date signed 3/20/45

Physician for Medical Examiner

G27058 ✓ G27058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 Lanvale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clifford H. Bewig, Sr. 3/17/45

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 19-1903

8. AGE: Years: 41 | Months: 7 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Fireman

11. Industry or business

FATHER
12. Name: John Bewig
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Anna Mae Knight
15. Birthplace: Maryland

16 (a) Informant: Mina Bewig
(b) Address: 428 N. Lanvale Ave.

17. Burial (Burial, cremation, or removal) (b) Date thereof: 3/21/45 (month) (day) (year)
(c) Cemetery or crematory: Balt. Cem.
Location: E. North. Ave.

18 (a) Funeral director: John A. Hogan
(b) Address: 1918 E. Balt. St.

19 (a) MAR 20 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 3 ~~P.M.~~ 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: March 17 1945 at 12 M.
(b) Where did injury occur? Washington St near Fayette
(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? Yes
(d) Means of injury: Beaten

23. Signature: Robert Lee Fristoe M.D. Medical Examiner.
Date signed: March 18 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

(Book) X

G27059 ✓ G27059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 E. Hoffman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1867

8. AGE: Years	Months	Days	If less than one day
77	11	26	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Dress-Maker

11. Industry or business

FATHER
12. Name Wm. H. Morrow
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J. Morrow
15. Birthplace Md.

16 (a) Informant Elizabeth Johnson
(b) Address 2035 E. Hoffman St.

17 (a) Burial (b) Date thereof 3/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Howard N. Bright Jr.
(b) 1901 Main Road Huntingtown Williamsport Md

19 (a) MAR 20 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18 1945, at 6.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1942 to 3/18 1945, and that I last saw h[illegible] alive on 3/17 1945.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic CVHD	
Due to Gen. Arteriosclerosis Chronic Arthritis	
Other Conditions Senility General Debility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard N. Bright Jr. M.D.
Address 2511 Reisterstown Rd. Date signed 3/19/45

VS 150

X

G27060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G27060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 N. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 505 N. Caroline st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fowlkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1898

8. AGE: Years	Months	Days	If less than one day
46	3	6	hr. min.

9. Birthplace Jennings Ordinary, Va
(Town, county, and state)

10. Usual Occupation painter

11. Industry or business

FATHER 12. Name William Fowlkes

13. Birthplace Va

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Alma Jones

(b) Address 505 N. Caroline St.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Jennings Ordinary, Va

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 MAR 20 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to Mar 18 1945, and that I last saw h.. alive on Mar. 18 1945.

Immediate cause of death Coronary Thrombosis — Duration 1 day.

Due to Cardiac decompensation

Due to Myocarditis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Lafont M.D.

Address 512 N. Broadway Date signed 3/21/45

VS 150

627061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 627061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Fayette & Paca

(c) Hospital or institution: Bon Secours Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 247 N Monroe St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Katherine Cantwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1871

8. AGE: Years 74 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John R Chambers

13. Birthplace Md

MOTHER 14. Maiden Name Catherine Gault

15. Birthplace Md

16 (a) Informant Mrs Lewis M Bishop

(b) Address 247 N Monroe

17 (a) Female (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)

(c) Cemetery or crematory Carlton of Location Balt Md

18 (a) Funeral director George E Farley

(b) Address Fayette & Paca

19 (a) MAR 20 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/1945, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/1945 to 3/17/1945, and that I last saw h.e.r alive on 3/17/1945

	Duration
Immediate cause of death: Adenocarcinoma of Pancreas & Hemorrhage	
Due to: Hypertension	3 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 3/15/45

Major findings of operation: Pancreas & Hemorrhage

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas Norris M.D.

Address 1 E Lexington Sq. Date signed 3/17/45

VS 150

G27062

TN. G27062 50139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G27062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 - 4 - 3
(e) Length of stay in Baltimore (yrs., mos., or days): 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1938 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Lula Hogue

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Oliver Hogue

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 11th, 1859

8. AGE: Years: 86 | Months: 1 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: James Adelsberger (D
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Owen (D
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/20/45 (month) (day) (year)
(c) Cemetery or crematory: St Joseph's Cem
Location: Emmitsburg, Md

18 (a) Funeral director: John J Bowan & Son
(b) Address: 901-03 Baltimore St

19 (a) MAR 20 1945 (b) Registrar
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1945 19 , at 4.37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14-39 19 to 3-17-45 19 , and that I last saw her alive on 3-17-45 19

	Duration
Immediate cause of death: Bronchopneumonia	48 hrs
Due to: Senility	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: 1941

Major findings of operation: Cervical polyps

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: E J Perry M. D.
Address: B C H Date signed: 3-19-45 M. D.

G27063 VS - 85256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27063 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 3 - 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Burton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Susie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1876

8. AGE: Years	Months	Days	If less than one day
68	8	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Samuel Burton (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Louise ? (D)
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B.A.Co. Md.

18 (a) Funeral director Isaiah Brown Son
(b) Address 1084 W Monty omery Street

19 MAR 20 1945 (Date rec'd by registrar) Huntingtown, Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945, at 3.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1943, to Mar. 16 1945, and that I last saw him alive on March 16 1945.

Immediate cause of death	Duration
Cardiac failure	?
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. M. Phillips
Address Balt City Hosp Date signed 3/18-45

G27064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G27064
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 St. Georges Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 St. Georges Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE AGNES TRACKETT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob P. Trackett
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.): Apr. 23, ~~1881~~ 1881

8. AGE: Years 62 | Months 10 | Days 24 | If less than one day: hr. min.

9. Birthplace: Cooperstown, Wis.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER
12. Name: Mark Nachtwey
13. Birthplace: Cooperstown, Wis

MOTHER
14. Maiden Name: Celia Fitzmaurice
15. Birthplace: Cooperstown, Wis

16 (a) Informant: Mrs. Lloyd Reynolds
(b) Address: 801 St. Georges Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-45 (month) (day) (year)
(c) Cemetery or crematory: St. Marys Cemetery
Location: Appleton, Wisconsin

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 20 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 6. A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1943 to March 19 1945 and that I last saw h— alive on March 18 1945

Immediate cause of death: Arteriosclerotic heart disease — Duration 5 years.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: H. S. Chaffee M. D.
Address: 6210 York Road Date signed: March 19 45

VS 150

G27065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1270

G27065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Rose Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Springlake Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MILTON Jay FIREY

3 (b) If veteran, name war Nonе | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maude J. Firey

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb 29 1878

8. AGE: Years 67 | Months 0 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Bath Haven, Penna. (Town, county, and state)

10. Usual Occupation Hotel Manager

11. Industry or business Congress Hotel

FATHER 12. Name Milton I. Firey

13. Birthplace Clear Spring, Md.

MOTHER 14. Maiden Name Cynthia A. Criley

15. Birthplace Mansfield, Ohio

16 (a) Informant Mrs. M. J. Firey (wife)

(b) Address 5201 Springlake Way, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) ____ (b) ____ Registrar
(Date rec'd by registrar)

MAR 20 1945 Huntington Williams, M.D.

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 1945, at 6:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1945 to 3/19/45 19__, and that I last saw h.[illegible] alive on 3/19 1945

Immediate cause of death Resp. Failure — Duration

Due to ____

Due to ____

Other Conditions Post-operative Renal insufficiency
(Include pregnancy within 3 months of death)

Date of operation 3/13/45

Major findings of operation: Carcinoma Undifferentiated

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Chas. E. Cattell

Address Redwood & Green Sts. Date signed M. 3 D. 19/45

G27066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1570

G27066 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 Albermarle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Albermarle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvia Anna Keener

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day) hr. 30 min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John R Keener
13. Birthplace W. Va.

MOTHER 14. Maiden Name Minie Keener
15. Birthplace W Va.

16 (a) Informant John Keener
(b) Address 131 albermarle

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Shipped
Location Parsons W. Va

18 (a) Funeral director William Fiallo Funeral Home
(b) Address 1618 Eastern Ave

MAR 20 1945 (Date rec'd by registrar) (Huntington for Williams, M.D.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Anencephalic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed March 20 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G27067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 Albermarle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Albermarle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Marie Keener

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			4 hr. 30 min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John R Keener
13. Birthplace W. Va.

MOTHER
14. Maiden Name Minnie Dawson
15. Birthplace W. Va.

16 (a) Informant John Keener
(b) Address 131 albermarle St

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-24-45 (month) (day) (year)
(c) Cemetery or crematory Shipped
Location Parsons W. Va.

18 (a) Funeral director William Fiel Kowski
(b) Address 1618 Eastern Ave

19 MAR 20 1945 (Registrar) Huntington for Williams Md (Address)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed March 20 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

G27068 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Hampton. (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-43

8. AGE: Years	Months	Days	If less than one day
1	4	13	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rosse Mitchell
13. Birthplace Va.

MOTHER 14. Maiden Name Kathryn Wood.
15. Birthplace Va

16 (a) Informant Ronda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20 1945 (month) (day) (year)

(c) Cemetery or crematory Newport News, Virginia
Location

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1903 Huntington Ave. Williamsburg, Va.

19 (a) Filed (Date received by Registrar) MAR 20 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1945 to March 19 1945 and that I last saw him alive on March 19 1945.

Immediate cause of death	Duration
Chronic pneumonia	
Due to Cystic fibrosis of	
Due to the pancreas	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature John R. Bumingham M. D.
Address JHH Date signed 3-20-45

627069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B 627069 Registered No. 698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Speaks

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Helen Speaks
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 28 1909

8. AGE: Years 36 | Months - | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Wm. Speaks
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace unknown

16 (a) Informant Helen Speaks
(b) Address 922 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Hep. D. Kelsay
(b) Address 1303 Freedman St

19 (a) MAR 20 1945 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-1945, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10-1945 to 3-17-1945 and that I last saw him alive on 3-16-1945

Immediate cause of death: Pulmonary Hemorrhage caused by Pulmonary Tuberculosis

Duration
15 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A Seminsky M. D.
Address 1029 N. Stricker St Date signed 3-20-45

G27070

JO #32510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1--8--18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Lizzie (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1874

8. AGE: Years	Months	Days	If less than one day
70 ?	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name James Duvall (d)
13. Birthplace ?

MOTHER
14. Maiden Name Prudence Henson (d)
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. D. Kelbaugh
(b) Address 1303 Russalman St.

19 (a) MAR 20 1945 (Date rec'd by registrar) Hunting [illegible]

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 16, 1945 at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28, 1943, to Mar. 16, 1945, and that I last saw him alive on Mar. 16, 1945.

	Duration
Immediate cause of death Pulmonal Circulatory failure	12 hrs.
Due to Unknown Cause	
Due to	
Other Conditions Arteriosclerosis Heart disease	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. Phillips M. D.
Address Balto City Hosp Date signed 3-18-45

G27071 469890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27071 Registered No. 44B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur E. Lloyd.
3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-27

8. AGE: Years	Months	Days	If less than one day
17.	5	27	hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilbur Lloyd
13. Birthplace md.

MOTHER
14. Maiden Name Madge Bowdy.
15. Birthplace md.

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20 '45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn Md.
18 (a) Funeral director Fred. A. Kramer & Son
(b) Address 1816 N. Charles St.
19 MAR 20 1945 (Date received) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 2.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1945 to March 17 1945, and that I last saw h[illegible] alive on March 17 1945

Immediate cause of death: Hodgkin's disease — Duration 7 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 3/17/45

VS 180

27072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 27072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood - Greene St's.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3117 Brighton St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George E Wagner Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-14-8482

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Edna E Hilgartner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1889

8. AGE: Years	Months	Days	If less than one day
55	6	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Time Keeper

11. Industry or business Beth Steel Co.

FATHER

12. Name John Wagner

13. Birthplace Md.

MOTHER

14. Maiden Name Catherine Lentz

15. Birthplace Md

16 (a) Informant Mrs Edna E Wagner

(b) Address 3117 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3901 Frederick Rd

18 (a) Funeral director Harry H Wilkes

(b) Address 4101 Edmondson Ave.

MAR 20 1945 (Date received by Registrar)

(b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-45 19 at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 19 45 to 3-19 19 45 and that I last saw him alive on 3-19 19 45

Immediate cause of death Coronary Failure — Duration 4 Days

Due to Asphyxia, fatigue

Due to Pulmonary Infarcts, Edema — 4 Days

Other Conditions Old intermittent Heart disease — 40 years?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D Gleason M. D.

Address Univ Hosp Date signed 3-19-45

X

G27073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 994a G27073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Riviera Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Herring

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-8741

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife. Rhoda M. McCahan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1891

8. AGE: Years 54 45 | Months | Days 20 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Tobacco Merchant

11. Industry or business Lilly Dunbar & Co.

FATHER
12. Name Ezra Herring
13. Birthplace West Virginia

MOTHER
14. Maiden Name Rosa M. Bell
15. Birthplace West Virginia

16 (a) Informant Mrs Rhoda M. Herring
(b) Address Riviera Beach Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Henry N. Wittstadt
(b) Address 4401 Edmondson Ave

19 (a) MAR 20 1945 (Date rec'd by registrar) (b) Huntington Williams Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at 10 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Ens death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Feather M.D.
Medical Examiner.
Date signed March 18 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G27074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Yale Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ETTA AGNES RYAN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1889

8. AGE: Years 55 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Lynchburg Va.
(Town, county and state)

10. Usual Occupation Dietitian

11. Industry or business Domestic, Sister Gift

FATHER
12. Name John J. Ryan
13. Birthplace Lynchburg, Va

MOTHER
14. Maiden Name Lelia Kraft
15. Birthplace Baltimore Md.

16 (a) Informant Ruth K. Ryan
(b) Address 329 Yale Ave

17 (a) Removal (b) Date thereof 3/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Lynchburg, Va.

18 (a) Funeral director Williams Cook Inc
(b) Address 1267 Pratt St.

19 MAR 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1945, at 7:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1945, to 3/19 1945, and that I last saw him alive on 3/19 1945

Immediate cause of death	Duration
Acute Congestive Heart Failure	Few hrs.
Due to Hypertension C.V. Disease	—
Due to —	—
Other Conditions Paralytic Ileus (P.O. Pan Hysterectomy) (Include pregnancy within 3 months of death)	5 Days

Date of operation 3/13/45
Major findings of operation: Adenocarcinoma of Uterus
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Ryan M. D.
Address Bon Secours Hosp Date signed 3/19/45

VS 150

G27075

JO #85702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G27075
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 2 mos. 16da.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John M. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Alatar (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1871

8. AGE: Years	Months	Days	If less than one day
74	-0-	12	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Unable to obtain information
11. Industry or business

FATHER
12. Name Henry Davis (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Eliza Trice (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (Date rec'd by registrar) MAR 20 1945 (Signature) Huntington Williams M.D.

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1943, to Mar. 18, 1945 and that I last saw him alive on Mar. 18, 1945.

Immediate cause of death	Duration
Bronchopneumonia	7
Due to	
Due to	
Other Conditions Hypertensive Cardio Vascular Disease Gen. Arteriosclerosis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 3-19-45

107

G27076 G27076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 N. Newkirk St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 N. Newkirk St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Elizabeth Bronzert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alex Bronzert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 / 92

8. AGE: Years: 52 | Months: 10 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Home Wife

11. Industry or business

FATHER
12. Name: Ignac Kmiach
13. Birthplace: Poland

MOTHER
14. Maiden Name: Anna Goralski
15. Birthplace: Poland

16 (a) Informant: Alex Bronzert
(b) Address: 901 N. Newkirk St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/21/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Baltimore

18 (a) Funeral director: Fred W Ozazewski
(b) Address: 1930 Eastern Ave.

19 (a) (Date received by Registrar) (b) Registrar

MAR 20 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19 44 to Mar 18 19 45 and that I last saw h alive on Mar 18 19 45

Immediate cause of death: Hypostatic Pneumonia — Duration: 3/17/45

Due to: Complications of Cirrhosis — 9/44

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William J Ryan M. D.

Address: 801 N Broadway Date signed: 3/19/45

X

G27077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27077
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3639 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3639 Falls Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Davis Simpson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19-1856

8. AGE: Years 88 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Isle of Wight Co Virginia (town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Simpson
13. Birthplace Wales

MOTHER
14. Maiden Name Catherine D. Jones
15. Birthplace Virginia

16 (a) Informant John Broadfield Simpson
(b) Address 3639 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22-1945 (month) (day) (year)
(c) Cemetery or Crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150 MAR 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20. 1945, at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20th 1945, to March 20th 1945, and that I last saw h[illegible] alive on March 20th 1945.

Immediate cause of death.	Duration
Myocardial Degeneration	[illegible] yrs
Due to Arteriosclerosis	[illegible] yrs
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Shotwell M.D.
Address 306 N. Calvert St. Date signed March 20/45

Approved: Robert Lee Graham M.D. 3/20/45

G27078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3430 Seneca Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3430 Seneca Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Edward Phillips

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes Ann Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5-1874

8. AGE: Years 70 | Months 5 | Days 13 | If less than one day: hr. min.

9. Birthplace Cella, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City of Baltimore

FATHER
12. Name David Phillips
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Smith
15. Birthplace Maryland

16 (a) Informant Mrs. Agnes Ann Phillips
(b) Address 3430 Seneca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) MAR 20 1945 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18-1945 at 4:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to March 18 1945 and that I last saw him alive on 3-17 1945.

Immediate cause of death: Cerebral Thrombosis — Duration: 2 wks
Due to: Arteriosclerotic CVD — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Shumaker M. D.
Address 3711 Falls Rd Date signed 3-17-45

X

G27079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G27079

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 N. Brice Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Brice Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Cornelia Moore

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris E. Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 5-1903

8. AGE: Years 41 | Months 11 | Days 3 | If less than one day: hr. min.

9. Birthplace: Cockeysville, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: William Thomas Corbin
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Virginia Laura Sears
15. Birthplace: Maryland

16 (a) Informant: Morris E. Moore
(b) Address: 623 N. Brice Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 22-1945 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore Co. Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Hunting Registrar

VS 150 MAR 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 6.27 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1945 to March 17 1945, and that I last saw her alive on March 17 1945.

Immediate cause of death: Carcinomatosis of Cervix with Metastases. — Duration 4 yr

Due to

Due to

Other Conditions: Hypertension Congestive (Include pregnancy within 3 months of death) — 3 days

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Darley
Address 617 Mulberd Ave Balto Date signed 3/19/45

Darley X

G27080

AB-82215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G27080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 8mos-19days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 13
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12- 1860

8. AGE: Years 84 | Months 7 | Days 21 29 | If less than one day ..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Reed
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Hayes
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL MAR 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 20 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10- 1945, at 8.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22- 1945, to 3-10 1945, and that I last saw h im alive on 3-10- 1945.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Generalized Arteriosclerosis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 3-19-45

2590

627081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1179

627081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 FAIT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 FAIT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD P. RAAB

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife MARY RAAB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 12 1882

8. AGE: Years	Months	Days	If less than one day
62	11	6	hr. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation BREW MASTER
11. Industry or business GLOBE BREWERY

FATHER
12. Name JOHN G. RAAB
13. Birthplace GERMANY

MOTHER
14. Maiden Name KUNGUNDA PICKLE
15. Birthplace GERMANY

16 (a) Informant ANNA D. RAAB (DAUGHTER)
(b) Address 3908 FAIT AVE.

17 (a) BURIAL (b) Date thereof MAR. 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Geile Co
(b) Address 403 S. WOLFE ST.

19 MAR 20 1945 (b) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH MAR. 18 1945, at 8/45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1945 to 3/18 1945, and that I last saw h/ alive on 3/18 1945.

Immediate cause of death Bleeding Gastric Ulcer — Duration 1 Day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Rudbourne M.D.
Address 1076 S. East Ave. Date signed 3/19/45

Huntington Williams, M.D. Registrar

Mitchell F. Rudbourne

VS 150

G27082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G27082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Patapsco Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Patapsco Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad C. Rutland

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	W.

6 (b) Name of husband or wife Jennie Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1864

8. AGE: Years	Months	Days	If less than one day
80	3	8	hr. min.

9. Birthplace Balto City.
(Town, county, and state)
10. Usual Occupation Ret. - Life G
11. Industry or business Watchman

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 421 Patapsco Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director Jos. L. McCauley
(b) Address 120 S. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAR 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 7:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 10 1945 to March 17 1945, and that I last saw h[illegible] alive on March 5 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 months
With hemiplegia	
Due to Arteria Sclerotic Cardio-	
Due to Vascular Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Latimer
Address 320 Patapsco Ave. Date signed 3/19/45

X

G27083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27083 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Druidhem & Eaton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Eaton.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Rest Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Helen Rest

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Cornelius James Rest
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept 7, 1882

8. AGE: Years: 62 | Months: 6 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: George Palmer
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Sarah Catherine Freeland
15. Birthplace: Freeland, Md.

16 (a) Informant: Cornelius J. Rest
(b) Address: 603 Rest Ave Eaton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 23, 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion
Location: Freeland Md.

18 (a) Funeral director: Easton Home
(b) Address: Ellicott City, Md.

19 (a) MAR 20 1945 (Date received by registrar) (b) Huntington Mills, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1945, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1945 to 3/20 1945, and that I last saw h[illegible] alive on 3/20 1945.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	2 years
Due to	
Due to	
Other Conditions: none	

(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: George E. Bungtop
Address: Ellicott City, Md. Date signed: 3/20/45

VS 150

G27084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G27084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH J. MANAHAN

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/1859

8. AGE: Years 86 | Months 0 | Days 28 | If less than one day hr. min.

9. Birthplace Emmittsburg, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Manahan
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Kirby
15. Birthplace Unknown

16 (a) Informant Mrs. Margaret Williamson
(b) Address 532 Rossiter Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 MAR 21 1945 (b) Registrar
(Registered by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Febr 1 19 45 to March 19 1945 and that I last saw h[illegible] alive on March 19 19 45

Immediate cause of death: Uremia
Due to Chronic Cardio Vascular Renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 Month

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Arkwright M D
Address 1911 W North Ave Date signed 3/20/45

VS 150

X

G27085 ✓ G27085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Bucke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Bucke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1890

8. AGE: Years: 54 | Months: 6 | Days: 11 | If less than one day: hr. min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Sharrett
13. Birthplace: British W. Indies

MOTHER
14. Maiden Name: Rachel Satterwood
15. Birthplace: Georgia

16 (a) Informant: Andrew Sharrett
(b) Address: 1510 E. Madison St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-22-45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: A. A. County Md.

18 (a) Funeral director: Joseph D. Lockard
(b) Address: 1304 N. Central Ave

19 (a) (Date received by registrar) MAR 21 1945 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945, at 9 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 18 1945

G-27086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G27086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 704 Reservoir St.

(c) Hospital or institution: none

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 704 Reservoir St.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Aubrey Bird

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lucy L. Souder

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) October 19, 1871

8. AGE: Years	Months	Days	If less than one day
73	5	-	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Martin Gillett & Co.

11. Industry or business

FATHER
12. Name Dr. Benjamin L. Bird
13. Birthplace Md.

MOTHER
14. Maiden Name Nannie O. Hodges
15. Birthplace Md.

16 (a) Informant Mrs. Lucy S. Bird
(b) Address 704 Reservoir St.

17 (a) Burial (b) Date thereof 3/21/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAR 21 1945 Huntington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/16/45 19 to 3/19 1945.
and that I last saw h[illegible] alive on 3/18/45 19

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Arteriosclerotic Heart Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Jack R. Morgan, M.D.

Address 8 E. Read St. Date signed 3/20/45

VS. 150

G-27087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. G-27087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catons.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Rosewood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hallie Shinnamon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis L. Shinnamon

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb 6 1891

8. AGE: Years 54 | Months 1 | Days 14 | If less than one day ____hr. ____min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vaughn A.
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Belle
15. Birthplace Md.

16 (a) Informant Louis L. Shinnamon
(b) Address 115 Rosewood Ave. Catons

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 23/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Boulevard

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1700 Eutaw Place

19 MAR 21 1945 (Date rec'd by registrar) Funeral for Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1945, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1945 to 3-20 1945; and that I last saw her alive on 3/20 1945

Immediate cause of death Circulatory collapse — Duration

Due to Adenocarcinoma of the rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Adenocarcinoma of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A. Olivares de Chanden M. D.

Address Date signed 3/20/45

VS 150

X

7088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G27088 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Dolfield Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Dolfield Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (d) FULL NAME Lena Schofer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Not known
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Herman Schofer
(b) Address 4102 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Rhode Island & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 MAR 21 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21-45 19..., at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to 3-21 1945 and that I last saw her alive on 3-21 1945

Immediate cause of death Cerebral Hemorrhage — Duration 3 hrs
Due to Arteriosclerosis
Due to —
Other Conditions Coronary Artery Disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X Milton Kirsch M.D.
Address 2904 Eutaw Pl. Date signed 3/24/45

7089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G-7089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairfaxtts Home
(c) Hospital or institution: 1701 N. Ellamont St 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIE WITENFELD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Witenfeld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Jack Kreimerman
(b) Address 2034 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)
(c) Cemetery or crematory Pikesville Memorial Park
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1431 E. Balto St

MAR 21 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945, to 3-19 1945, and that I last saw h[illegible] alive on 3-19 1945.

Immediate cause of death	Duration
Generalized arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund L Levine

Address 3400 Hilton Rd Date signed 3/19/45

VS 150

G27090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1018 Greenmount
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Greenmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Simon Levy

3 (b) If veteran, name war? | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Sarah -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace ? Russia (Town, county, and state)
10. Usual Occupation Rhymaker
11. Industry or business Belt

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant Robert Levy
(b) Address 1018 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem'
Location Wash. Rd.

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St

19 MAR 21 1945 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 8.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Hearing thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Varicose ulcers, legs

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. B. Davis M.D. Medical Examiner.
Date signed 3/20/45

7091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G27091 (new)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution: Redwood and Greene Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Manchester.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia Hain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Jacob Hain
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Mary Hain.
(b) Address Manchester, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23 1945 (month) (day) (year)
(c) Cemetery or crematory Manchester Cem.
Location Manchester, Md

18 (a) Funeral director Jacob Winter Sons
(b) Address Manchester, Md.

MAR 21 1945 (Date rec'd by registrar) (b) Huntington-Williams Co. Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-45 19____, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1945 to 3-20 1945, and that I last saw her alive on 3-20 1945

Immediate cause of death	Duration
Exhaustion, cardiac failure	
Due to Subarachnoid Hemorrhage	6 Days
Due to Arteriosclerosis + Hypertension	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Not granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Gleason M. D.
Address Univ. Hosp. Date signed 3-20-45

G-27092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

✓ G27092 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2954 Keswick Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2954 Keswick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer R. Rogers

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-8258

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married.

6 (b) Name of husband or wife Eva J. Rogers.
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec 5. 1878

8. AGE: Years	Months	Days	If less than one day
66	3	14	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired Freight Conductor
11. Industry or business Penna. R.R.

FATHER 12. Name Wm. H. Rogers.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Emma J. Hurley.
15. Birthplace Maryland

16 (a) Informant Eva J. Rogers.
(b) Address 2956 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Shanowalt & Donovan
(b) Address 3615-17 Christian Ave.

19 (a) Date received MAR 21 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945; at 1 20 a M

21. I certify that death occurred on the date above stated, that I attended deceased from March 1944 to March 19 1945 and that I last saw h[illegible] alive on March 19 1945

Duration
Immediate cause of death: E Pneumonia	1 wk.
Due to	
Due to	
Other Conditions Arrhosis? Liver (Include pregnancy within 3 months of death)	indef.

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 11 E W. 20 St Date signed Mar 20 45

X

G27093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G27093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 E.Port St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 E.Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Icenroad Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie Icenroad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1881

8. AGE: Years	Months	Days	If less than one day
63	7	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Cooper
11. Industry or business Kimble & Tyler

FATHER
12. Name John Icenroad
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Icenroad
(b) Address 400 E.Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.22-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John G. Miller
(b) Address 2234 Jefferson St.

19 (a) MAR 21 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 1945 at 4.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 19 to March 18 1945 and that I last saw h alive on March 18 1945.

Immediate cause of death Coronary Occlusion

Due to Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Sauber M. D.
Address 100 N. Mullen Date signed 3/21/45

627094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

627094 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st S.,
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT MAX TALBOT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife Amanda E. Mintz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Lieutenant---USCG
11. Industry or business

FATHER
12. Name Joseph Talbot
13. Birthplace Germany

MOTHER
14. Maiden Name Mathilda
15. Birthplace Germany

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Date rec'd by Local Reg.) (b)

MAR 21 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945, at 10:00pm

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945, to March 17 1945, and that I last saw him alive on March 17 1945

Immediate cause of death	Duration
Carcinoma of rectum	8 mo.
Myocardial degeneration	Unk.
Due to Chronic auricular fibrillation	Unk.
Due to Arteriosclerotic heart disease, arteriosclerosis, General	Unk.
Other Conditions Peritonitis, acute, pelvic, due to rupture of rectum	6 da.
Ileus, paralytic (within 3 months of death)	5 da.

Date of operation 3/16/45
Major findings of operation: Cecostomy
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin F. Jones, M.D.
Address US Marine Hospital, Baltimore, Maryland Date signed 3/19/45

G27095 G27095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2424 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Gilbings

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1905

8. AGE: Years	Months	Days	If less than one day
40	-	18	hr. min.

9. Birthplace Philadelphia (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Allen Carter
13. Birthplace Hanover Co. Va.

MOTHER
14. Maiden Name Annie Kinney
15. Birthplace Va

16 (a) Informant John E Gilbings
(b) Address 2424 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Robert A. Elliott & Son
(b) Address 1129 N. Carrollton Ave

19 (a) MAR 21 1945 (Date rec'd by registrar) Huntington Undertaking Co. (Signature of Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-45 19..., at 7:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16- 1945, to 3-18- 1945.
and that I last saw h[illegible] alive on 3-18 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hrs
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Alex Flora M. D.
Address 312 E 33rd St Date signed 3-20-45

G27096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 L

Registered G27096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 dys.
(e) Length of stay in Baltimore (yrs., mos., or days): None

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Balto.
(c) City or town: Delight
(If outside city or town limits, write RURAL and give town)
(d) Street No.: near Owings Mills,
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: —

3 (a) FULL NAME: Barbara Parker

3 (b) If veteran, name war:

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, ~~married, widowed, or~~ divorced: S.

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1892

8. AGE: Years: 52 | Months: 6 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Reisterstown, Balto. Md.
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Fire Insurance Company

FATHER
12. Name: Alfred S. Parker
13. Birthplace: Reisterstown, Md.

MOTHER
14. Maiden Name: Mareb Worrell
15. Birthplace: Reisterstown, Md.

16 (a) Informant: Emma Parker
(b) Address: Delight, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 22, '45 (month) (day) (year)

(c) Cemetery or crematory: Black Rock
Location: Butler, Md.

18 (a) Funeral director: Wm. Berryman & Sons
(b) Address: Reisterstown, Md.

19 (a) (Date received by registrar): MAR 21 1945 (b) Address: Huntington Millerville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 19 1945; at 12 ~~M~~ Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18/45 19 to 3/19/45 19, and that I last saw her alive on 3/17 19.

Immediate cause of death: Emb. Failure — Duration

Due to: Ca of Head of Pancreas.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: No

Major findings of operation:

of autopsy: Ca of Head of Pancreas.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Chas. E. Collet M. D.
Address: Reisterstown Md. Date signed: 3/19/45

X

G27097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F Registered No. G27097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1522 BETHEL ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 56

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL BASTIGKEIT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex M | 5 Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name ~~of husband or wife~~ Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10-1865

8. AGE: Years 80 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Not Known

MOTHER / FATHER
12. Name Not Known
13. Birthplace Germany
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Katherine Bastigkeit
(b) Address 1522 Bethel St

17 (a) Burial (b) Date thereof 3/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity
Location St Donnals Rd

18 (a) Funeral director Geo Leyenbach
(b) Address W N Eutaw St.

19 (a) [illegible] Hunter for Williams M.D. Registrar
(b) Date received MAR 21 1945

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 45 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to March 19 45 and that I last saw ~~her~~ alive on March 19 45

Immediate cause of death: Carcinoma of Liver — Duration 2 yrs
Due to —
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest L. Zimmerman M. D.
Address 2458 Harford Date signed 3/19/45

G27098

BALTIMORE CITY HEALTH DEPARTMENT ✓ G27098
CERTIFICATE OF DEATH 83a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4036 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4036 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY VIRGINIA BORING

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George W. Boring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1872

8. AGE: Years 72 | Months 6 | Days 3 | If less than one day ____hr. ____min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joshua Wilhelm
13. Birthplace Md.

MOTHER
14. Maiden Name --
15. Birthplace Md.

16 (a) Informant Mr. William G. Boring
(b) Address 4036 Roland Ave.

17 (a) Burial (b) Date thereof 3/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hampstead Cem.
Location Hampstead, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ____ (b) ____
Registrar

MAR 21 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to 19 March 1945; and that I last saw her alive on 19 March 1945.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Arteriosclerosis

Due to: Hypertension

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ✓ at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Truett, M.D.
Address 712 Park Ave Date signed 3 March 1945

X

G27099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

942

G27099

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 East Preston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM R. BROWN

3 (b) If veteran, name war --

3 (c) Social Security Account No. 215-03-0258

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth E. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1887

8. AGE: Years 57 | Months 5 | Days 20 | If less than one day ....hr. ....min.

9. Birthplace Kent Island, Queen Anne Co., Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Re-Placements Parts Co.

FATHER
12. Name John F. Brown
13. Birthplace Kent Island, Md.

MOTHER
14. Maiden Name Laura V. Pancoast
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Ruth E. Brown
(b) Address 209 E. Preston St.

17 (a) Burial (b) Date thereof 3/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Stevensville, Kent Is., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by reg.) MAR 21 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 10:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....., at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Davis, M.D.
Medical Examiner.
Date signed 3/20/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85a

Registered No. 627100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Alto Road
(c) Hospital or institution: 1569
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Alto Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Brinker

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-3597

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth M. Brinker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	19 22	hr. min.

9. Birthplace Sharon, Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business General Ship

FATHER
12. Name John Brinker
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Powers
15. Birthplace

16 (a) Informant Mrs. Elizabeth M. Brinker
(b) Address 4102 Alto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) MAR 21 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945 at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1945, to March 18 1945 and that I last saw h[illegible] alive on March 19 1945

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	1 day
Due to (b) Arterial Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. R. Johnson M.D.
Address 403 Medical Arts Bldg. Date signed 3/19/45

VS 150

G27101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27101 / 1862 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be correctly supplied, and no certificate will be complete and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 943 S. Bouldin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (DOROTHEA) Dorothy MURDOCK

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: James L. Murdock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1855

8. AGE: Years 89 | Months 9 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Conrad Koch
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna
15. Birthplace: — Germany

16 (a) Informant: Mr Thomas Murdock
(b) Address: 943 S. Bouldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Patons

18 (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Aisquith St

19 (a) (Date rec'd by registrar) MAR 21 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20- 1945 at 7.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18- 1945 to 3-20- 1945 and that I last saw h[er] alive on 1:30 PM 3-20-45

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to Fractured hip.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/11
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-18-45 at M
(c) Where did injury occur? Baltimore (City or town) — (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Fall fracturing hip.

23. Signature [illegible] M.D.
Address 121 Light St Date signed 3-20-45

For C. J. Zebrowski, by Howard J. Mackey, M.D.

G27102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G27102 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dukeland + Payne
(b) Street address ~~446 N. Fulton Ave~~
(c) Hospital or institution: West Balto Gen'l Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Henry Crompton

3 (b) If veteran, name war: War 1

3 (c) Social Security Account No. 215-05-8709

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-17-96

8. AGE: Years 48 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation House Painter

11. Industry or business

FATHER 12. Name Harry Crompton.

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Louise Perkins,

15. Birthplace Unknown

16 (a) Informant Mrs Rose A. Crompton,

(b) Address 1416 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23. 1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location Baltimore Md.

18 (a) Funeral director Robert S. Little,

(b) Address 2700 Edmondson Ave.

19 (Signature of local registrar) MAR 21 1945 Acting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1945 to 3-20 1945 and that I last saw him alive on 3-19 1945

Immediate cause of death: Cachexia — Duration weeks

Due to: carcinoma ascending colon

Due to: & metastases

Other Conditions: Bronchopneumonia Dilated

(Include pregnancy within 3 months of death)

Date of operation 3-9-45

Major findings of operation: Unoperable Ca & retroperitoneal metastases

of autopsy: (same)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norton Benner M.D. M. D.

Address West Balto Gen'l Date signed 3-20-45

VS 150

G27103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3520 Hilton Rd.
(c) Hospital or institution: Mrs. Shriners Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days): 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 907 Bennett Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Emma R. Mahle

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1862

8. AGE: Years: 62 Months: 4 Days: 27 If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: John J. Mahle
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Shurr
15. Birthplace: Germany

16 (a) Informant: Frederick W. Green
(b) Address: 907 Bennett Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 22, 1945 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Balto. Md.

18 (a) Funeral director: Robert S. Little
(b) Address: 2700 Edmondson Ave.

19 (a) MAR 21 1945 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: March 19 1945, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19..., and that I last saw h... alive on ... 19...

Immediate cause of death	Duration
Carcinoma of breast (operated) with metastases	
Due to to lungs, liver, etc.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: about 5 yrs. ago

Major findings of operation: ulcerated breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Stuart Q. Levy

Address: 2322 Fountain Ave. Date signed: 3/20/45

X

G27104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 93D

G27104 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 Orleans Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 Orleans Street (If rural give location) 1438
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Taylor Davenport

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore Balto., Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Brown

(b) Address 1720 W. Lafayette ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1010 Bentley

19 (a) MAR 21 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1945, at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed March 20 1945

G27105 — BALTIMORE CITY HEALTH DEPARTMENT — G27105

CERTIFICATE OF DEATH 57D

Registered No.

Use ink or typewrite the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 Boarman Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Boarman Court Brokert Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil Johnson Millison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1922

8. AGE: Years 22 | Months 7 | Days 15 | If less than one day hr. min. 23

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace S. C.

MOTHER
14. Maiden Name Ella Millison
15. Birthplace S. C.

16 (a) Informant Chas Millison
(b) Address 1256 W West Street

17 (a) Burial (b) Date thereof 3/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Cedar Park
Location Q-a-6 Mer

18 (a) Funeral director Isaac L Brown
(b) Address 1911 W Monument St

19 MAR 21 1945 (Date rec'd by registrar) (b) Huntington Williamson, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 10 15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebellar Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraley M.D.
Medical Examiner.
Date signed 3-17-45

G27106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Eutaw Place.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Eutaw Place.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CONRAD GOULD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Regina R. Gould
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1879

8. AGE: Years	Months	Days	If less than one day
65	6	19	hr. min.

9. Birthplace France.
(Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Solomon Gould,
13. Birthplace France.

MOTHER
14. Maiden Name Unknown,
15. Birthplace France,

16 (a) Informant Mr. Justinus Gould,
(b) Address 2108 Eutaw Place.

17 (a) Burial (b) Date thereof 3.22.45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.
18 (a) Funeral director David Sonnheim & Son
(b) Address 1902 Eutaw Place.
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch. 20th. 1945, at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to March 20 1945, and that I last saw h[illegible] alive on March 20 1945.

Immediate cause of death	Duration
Acute Myocardial Insufficiency	3 hours
Due to Coronary Thrombosis	4 hours
Due to Hypertensive Cardio-Vascular Disease	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolff M. D.
Address 11 E. Chase St. Date signed 3/20/1945
Baltimore 2, Md.

Instituto Williams M.D.

G27107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937 D

G27107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 W. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norval H. Herbert

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Susie Herbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23rd 1870

8. AGE: Years 74 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Penna. R. R.

FATHER
12. Name James Herbert
13. Birthplace Unknown

MOTHER
14. Maiden Name Julia Cannon
15. Birthplace Md

16 (a) Informant Susie Herbert
(b) Address 14 W. Preston St

17 (a) Burial (b) Date thereof 3/26/45
(Burial, ~~cremation~~, removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) MAR 21 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1945, at 12 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1944, to Mar. 20, 1945, and that I last saw h~~im~~ alive on Mar. 20, 1945.

	Duration
Immediate cause of death: Acute Myocardial Failure	Immediate
Due to:	
Due to:	
Other Conditions: Chronic Myocarditis	2 years

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ~~None~~
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Francis M. Ogburn M. D.
701 N. Calvert St. Date signed Mar. 20, 1945

VS 130

X

G27108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27108 / 106a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Old Spring Lane
(c) ~~Hospital or~~ institution: Old Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Hayward Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Chas. E. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 9th 1848

8. AGE: Years 97 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name C.C. Batchlor
13. Birthplace Unknown

MOTHER
14. Maiden Name Liza Jane Johnson
15. Birthplace Md.

16 (a) Informant James A. Hamberry
(b) Address 2800 Mosher St

17 (a) Burial (b) Date thereof 3/22/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 21 1945 (b)
(Filed by Registrar) Registrar

Huntington for Miller, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1945, at 6 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944, to March 20 1945, and that I last saw h~~is~~er alive on March 16 1945.

Immediate cause of death: Cerebral hemorrhage

Due to

Due to

Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. N. Patterman M. D.

Address 7324 Reisterstown Rd. Date signed 3/24/45

G27109 G27109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 456

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Webb Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul F. Slattery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of ~~husband or~~ wife Marguerite Slattery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13th 1889

8. AGE: Years 55 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Pittsburg Pa.
(Town, county and state)

10. Usual Occupation Electrician.

11. Industry or business Journeyman

FATHER
12. Name Paul Slattery
13. Birthplace Pa

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Pa.

16 (a) Informant Margaret Wheeler
(b) Address 804 Webb Court

17 (a) Burial (b) Date thereof 3/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 21 1945 (b)
Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1945, at 5 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1945, to March 19 1945, and that I last saw h~~im~~ alive on March 19 1945

Immediate cause of death Carcinoma of tongue and tonsil — Duration

Due to

Due to

Other Conditions Gruzal metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. Kadow M. D.

Address 2306 Eutaw Pl Date signed 3-21-45

X

G27110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27110 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Tohn st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Tohn St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Tesdorpf

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Carl Tesdorpf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14th 1868

8. AGE: Years 76 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Lensehow
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte Trautwein
15. Birthplace Germany

16 (a) Informant Eleanor Lensehow
(b) Address 1519 John St.

17 (a) Burial (b) Date thereof 3/23/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Bork Inc
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MAR 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1945, at 8:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 20 1945 and that I last saw her alive on March 9 1945.

Immediate cause of death — Duration

acute Dilatation of Heart — 4 hrs

Due to Chronic Myocarditis — several years

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M. D.

Address 3-20-45. Date signed

G27111 — BALTIMORE CITY HEALTH DEPARTMENT — G27111 Registered No.

CERTIFICATE OF DEATH 56E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 Cambridge st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 / 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Cambridge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Ashe

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-5947

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 7th 1922

8. AGE: Years 22 | Months 9 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Sharrows Point, Md.
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Eastern Offset Inc.

FATHER — 12. Name John F. Ashe

13. Birthplace N. Y.

MOTHER — 14. Maiden Name Agnes Miller

15. Birthplace Md.

16 (a) Informant Mrs Agnes Stoliker

(b) Address 2324 Cambridge St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3/23/45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Balto. Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) MAR 21 1945 (Date received) Thaddeus J. Williams Registrar (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19th 1945, at 10 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1938, to Mar 18 1945, and that I last saw h alive on March 18 1945

Immediate cause of death	Duration
Hematoma	From Birth
Due to Hemophelia	
Due to Hemophelic Jaundice	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris Abramowitz M. D.
1705-07 E. Balto
Date signed 3/20/45

Morris Abramowitz

VS 150

G27112 Luehrs

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27112 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Staples St, N.E (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry P. Luehrs

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 578-09-1108

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ida T.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/6/1891 1892
8. AGE: Years 53 | Months 7 | Days 14 | If less than one day hr. min.
9. Birthplace N.Y.C (Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business Schneider Baking Co.

FATHER
12. Name ~~Mark~~ John Luehrs
13. Birthplace ~~Mark~~ Germany

MOTHER
14. Maiden Name ~~Mark~~ Catherine ?
15. Birthplace ~~Mark~~ Germany

16 (a) Informant Mrs Ida T. Luehrs
(b) Address 1314 Staples St NE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat'l.
Location Arlington, Va.

18 (a) Funeral director J. William Leis Son
(b) Address 300 F-4 St NE Wash. D.C.

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar)

21 1945 VS-191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1945 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Multiple fractures
~~Due~~ Acute Edema - Congestion of lungs

Other Conditions Contusions, lacerations and bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-17- at P.S. Loc. 7:30 A.M.
(b) Where did injury occur? Wash. Blvd, near Laurel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile
(e) Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 3-21-45

X

Roy

G27113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27113

Type or use ink. Enter the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5223 Linden Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ray H. Wheat

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-6107

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) Dec 1/1896

8. AGE: Years	Months	Days	If less than one day
48	3	19	hr. min.

9. Birthplace Rock Hall Md
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Samuel Thomas Wheat
13. Birthplace Maryland

MOTHER
14. Maiden Name Mollie L Urry URRY
15. Birthplace Delaware

16 (a) Informant Mrs George M Holmes
(b) Address 5223 Linden Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23/1945 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Rock Hall Md

18 (a) Funeral director Harry N Cummings
(b) Address 4204 Ridgewood Ave

19 (a) (b) Huntington Williams, M.D. Registrar

MAR 21 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1945, at 2:40 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 20, 1945.

X

27114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 27114

PRINT PLAINLY IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 723 Hollins
(b) Street address Balto.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Hollins
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hooker

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	L	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1855

8. AGE: Years	Months	Days	If less than one day
89	6	2	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business —

FATHER
12. Name William Abbott
13. Birthplace Va

MOTHER
14. Maiden Name Sallie Tyler
15. Birthplace Va

16 (a) Informant Maud Broxton
(b) Address 723 Hoffman

17 (a) Burial (b) Date thereof 3-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

(b) Name and address of informant Huntington Williams, Hdq

MAR 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 1945 5 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/11/1945 to 3/18/1945, and that I last saw him alive on 3/16/1945

Immediate cause of death Cerebral Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Stein M. D.
Address 723 Hoffman Date signed 3-19-45

VS 150

G27115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55a

G27115

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 S. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HENRY DAYHOFF

3 (b) If veteran, name war: World war 1
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Beulah C. Hahn
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) Mar. 23, 1894
8. AGE: Years 50 | Months 11 | Days 23 | If less than one day: hr. min.
9. Birthplace Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Jesse A. Dayhoff
13. Birthplace Frederick, Co., Md.

MOTHER
14. Maiden Name Elsie M. Hall
15. Birthplace Frederick Co., Md

16 (a) Informant Mrs. Beulah C. Dayhoff
(b) Address 232 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3- 22, 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945 at 3.49 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to March 19 1945; and that I last saw h alive on March 19 1945.

Immediate cause of death	Duration
Carcinoma Suprarenal Gland	8 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph Sindler M. D.
Address 1707 E. Fayette St Date signed 3/20/45

Huntington-Williams, Inc.

VS 180

FOUNTAIN WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27116

IN. 92308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V95B

G27116 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26- 6- 26

(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2234 N. Howard St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ~~Thomas Robert Willie~~ Robert Willie Thomas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23rd, 1918

8. AGE: Years	Months	Days	If less than one day
26	6	26	hr. min.

9. Birthplace Ga.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Adam Thomas

13. Birthplace Ga.

MOTHER

14. Maiden Name Ophina Pope

15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Old Frederick Rd

18 (a) Funeral director Peter L Wellings

(b) Address 1515 McElderry St

19 (a) MAR 21 1945 (Date received by registrar) Huntington Wellings Registrar

VS 150

MEDICAL CERTIFICATION 10.50 A

20. DATE OF DEATH March 19th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23rd 1918 to 3-19-45, and that I last saw him alive on Mar. 19 1945

Immediate cause of death	Duration
Cardiac failure	>
Due to Rheumatic heart disease	>
Due to Acute glomerulo nephritis	)
Other Conditions	)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 3-20-45

(over)

G27117 G27117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 93c

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Annapolis Ave. St. 23 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Clifton Wm Oliver

If U. S. Veteran specify WAR

(a) Residence: No. 2414 Annapolis Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. Color or Race Col

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) April 1895

7. AGE Years 49 Months 11 Days If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME John Clinton

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Mary Jacobs

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Joseph Morris

(Address) 2414 Annapolis Ave,

18. BURIAL, CREMATION, OR REMOVAL

Place National Date March 22 1945

19. UNDERTAKER Mrs. Katie R. Williams

(Address) 832 N. Schroeder St

20. MAR 21 1945 19 Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3/18/45

22. I HEREBY CERTIFY, That I attended deceased from August 1944 to 3/18/45 19

I last saw him alive on 3/18/45 19 Death is said to have occurred on the date stated above, at 8 a.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

1 Myocarditis 3 Mos

Other contributory causes of importance:

2 Apoplexy 6 Mos

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Howard A Glass M. D.

(Address) 1000 Madison Ave

OCCUPATION is very important. See instructions on back of certificate.

VS 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G27118
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 938 Wilmont Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 Wilmont Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Lee Haney

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Helen Rhoda Haney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1866

8. AGE: Years	Months	Days	If less than one day
79	1	16	hr. min.

9. Birthplace Baltimore Md.
(town, county, and state)
10. Usual Occupation Retired Labor
11. Industry or business

FATHER
12. Name Thomas G. Haney
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary V. McKnew
15. Birthplace Sidling Md.

16 (a) Informant Miss Helen R. Haney
(b) Address 938 Wilmont Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Mayo Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eagle St.

19 (a) (Signature of local registrar)

MAR 21 1945 Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20, 1945 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 13 1945 to 3/19 1945 and that I last saw him alive on 3/19 1945.

Immediate cause of death	Duration
(a) Myocarditis	
Due to acute cardiac failure	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. H. Hometeus M. D.
Address 733 Argonaut St Date signed 3/20/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G27119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27119 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 951 Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 951 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth Lokey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1912

8. **AGE:** Years 32 | Months - | Days 14 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name George Alexander
13. Birthplace Va

MOTHER 14. Maiden Name Cora Everhart
15. Birthplace Va

16 (a) Informant George Alexander
(b) Address 951 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-45 (month) (day) (year)
(c) Cemetery or crematory Holly Wood
Location Hamilton Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) MAR 21 1945 (Date received by registrar) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to March 14 1945, and that I last saw her alive on March 17 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: Couple yrs

Due to:

Due to:

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Ralph T. Yerry M.D.

Address 1424 Monument Date signed 3/20/45

G27120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27120

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 120 S. East. ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 120 S. East. Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary S. Hennessy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20-1863

8. AGE: Years 81 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business "

FATHER 12. Name Wm Hennessy

13. Birthplace Ireland.

MOTHER 14. Maiden Name Ann Devereus

15. Birthplace Ireland.

16 (a) Informant James Hennessy

(b) Address 120 S. East. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Loch.

Location Old Frederick Rd.

18 (a) Funeral director John A. Hahan

(b) Address 2000 E. Balto. St

MAR 22 1945 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1945 to Mar 19 1945, and that I last saw her alive on Mar 18 1945.

Immediate cause of death Cerebral Hemorrhage
Chronic myocarditis
Hypertension
Arteriosclerosis

Duration 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph Tankey M. D.

Address 441 S. Ellwood ave Date signed 3/20/45

VS 150

G27121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G27121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice C. Rice

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 24, 1895

8. AGE: Years 49 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name Charles Cook
13. Birthplace Virginia
14. Maiden Name Lucy Webster
15. Birthplace Virginia

16 (a) Informant Lucy Cook
(b) Address 313 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore County

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1056 Montgomery Street

19 (Signature) Huntington Williams, M.D. (Registrar)
MAR 22 1945 (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Mar 18 1945, and that I last saw h[er] alive on Mar. 17 1945.

Immediate cause of death: Valvular Heart Disease — Duration
Due to —
Due to Hypertension
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Shepperd M. D.
Address 1431 W Franklin St Date signed 3/21/45

G27122 ✓ G27122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Rowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1877

8. AGE: Years 67 | Months 8 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Fairmont, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Waters
15. Birthplace Md.

16 (a) Informant Mrs. Georgie Boggs
(b) Address 1633 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 23, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Filed MAR 22 1945 (b) ..... Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 20, '45 19..., at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 19 44 to 3-20 19 45 and that I last saw h[illegible] alive on 3-18-19 45

Immediate cause of death: Carcinoma of breast and metastasis — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Hunting M.D.
Address 600 Washington Blvd Date signed 3/27

Huntington Williams, M.D.

X

Please write plainly, with pen or indelible pencil. Do not use ink. Be sure to answer correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161 C

Registered No. G27123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 N. Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James N. Hardy Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1945

8. AGE: Years	Months	Days	If less than one day
		11	13 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James N. Hardy, Sr.
13. Birthplace Birmingham, Ala.

MOTHER
14. Maiden Name Marian Denell
15. Birthplace Baltimore, Md.

16 (a) Informant Marion Hardy
(b) Address 1404 Luzerne ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor ave.

18 (a) Funeral director Bowen N. Blight, Jr.
(b) Address 4914 Belair Road

MAR 22 1945
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1945, to March 21 1945, and that I last saw h[illegible] alive on March 21 1945.

Immediate cause of death Respiratory failure Duration

Due to Peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy Necessary clues

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Luckey M.D.
Address Sinai Hosp. Date signed March 22, 45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A ✓ Registered No. 627124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2559 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Henry G. Browning

3 (b) If veteran, name war	3 (c) Social Security Account No. 705-10-6583
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian E. Browning
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 10/7/1905

8. AGE: Years	Months	Days	If less than one day
39	5	12	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Ry Trackman
11. Industry or business Railway Mus. R.R

FATHER
12. Name Elias E. Browning
13. Birthplace Md

MOTHER
14. Maiden Name Eva K. Wiese
15. Birthplace Md

16 (a) Informant Lillian E. Browning
(b) Address 3319 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22 45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director J. A. Wimpert Son
(b) Address 850 W. Baltimore St.

MAR 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-1945 at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-20-45

G27125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G27125 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (Fairfield)
(c) Hospital or institution: Bethlehem Shipyards
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 or 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Cottage Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joe Gorol

3 (b) If veteran, name war

3 (c) Social Security Account No. 235-09-2321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Shipfitter

11. Industry or business Shipyard

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John Barley
(b) Address 3611 Cottage ave

17 (a) Burial (b) Date thereof 3/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick

18 (a) Funeral director Geo. J. Kenny
(b) Address Baltimore & Fulton

19 MAR 22 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1945, at 11 05 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gretzer M.D.
Medical Examiner.
Date signed March 20 1945.

VS 151

G27126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 398 W 29th St.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 398 W 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Baldwin.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced widow.

6 (b) Name of husband or wife Joseph N. Baldwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21, 1861

8. AGE: Years 83 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name David Hooper.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mary E. Butler.
(b) Address 398 W 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22/45 (month) (day) (year)
(c) Cemetery or crematory Dry Hill
Location Laurel, Md.

18 (a) Funeral director E. Kenworthy Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) MAR 22 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1943 to March 1945
and that I last saw her alive on March 19 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Hypertension Heart Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 8 W 36th St Date signed 3/24/45

Dr. Wallenstein

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627127 Ulrich

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55D

627127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: Balt. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Warren St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minetta Ulrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Arthur W. Ulrich

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1913

8. AGE: Years 31 | Months 6 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Mark Schisler
13. Birthplace Unknown

MOTHER
14. Maiden Name Lillian Heiges
15. Birthplace Unknown

16 (a) Informant Arthur W^m Ulrich
(b) Address 208 Warren Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John F. Denny Inc
(b) Address 715 Light St

19 (a) (Date rec'd by registrar) MAR 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1945 at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1945 to 3-20 1945 and that I last saw H alive on 3-20 1945

Immediate cause of death: Carcinoma of Ethmoid and Sphenoid Sinuses — Duration

Due to

Due to

Other Conditions debilitation

(Include pregnancy within 3 months of death)

Date of operation Dec 3 mos

Major findings of operation: proven by biopsy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 1211 Light St Date signed 3-20-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

27128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G27128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1635 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABLE F. MYERS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug. 18, 1886
8. AGE: Years 58 | Months 7 | Days 3 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Teacher
11. Industry or business: Dept. Edu., Balto. Public Schools

FATHER
12. Name: William C. Myers
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Martha J. Jay
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Clare Jenkins
(b) Address: 7419 Old Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAR 22 1945 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1945, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-23 1945 to Mch 21 1945, and that I last saw her alive on Mch 20 - 1945.

	Duration
Immediate cause of death: Edema of Brain	1 week
Due to: Lympho-Sarcoma of	2 yrs
Due to: Ro axilla	
Other Conditions: Metastases in Brain	2 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E North Ave Date signed March 21-45

VS 150

627129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 627129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: FLORENCE N. ACKERLY

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fred C. Ackerly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1880

8. AGE: Years 64 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Newark, N. J.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Stout
13. Birthplace New Jersey

MOTHER
14. Maiden Name Susan Emmons
15. Birthplace New Jersey

16 (a) Informant Mr. Fred C. Ackerly
(b) Address 2204 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 22 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1945 at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to March 21 1945 and that I last saw her alive on March 20 1945.

Immediate cause of death: Pneumonia
Interval

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Franklin M. D.
Address 1125 St Paul St Date signed 3-23-45

H. D. Franklin

G27130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 C

Registered No. G27130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Eastway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Eastway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EFFIE L. FENTRESS

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 988-20-1341

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles Wesley Fentress
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	17	hr. min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Hubert S. Ely
13. Birthplace Va.

MOTHER
14. Maiden Name Penelope S. White
15. Birthplace Va.

16 (a) Informant Mr. Robert L. Lemen
(b) Address 4502 Eastway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1945, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1945 to March 21 1945 and that I last saw her alive on March 20 1945

Immediate cause of death	Duration
Cerebrovascular accident -	1½ yrs.
Due to cerebral thrombosis and hemorrhage (see 2nd page)	
Due to Hypertension and Arteriosclerosis	10+ yrs.
Other Conditions Cardiac enlargement Previous episodes of cerebral failure	6 mos + 3 wks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Tallman M. D.
Address 3035 St. Paul St Date signed 3-21-45

VS 150

83a

G27131 G27131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Kellers Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ray McClain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10th 1924

8. AGE: Years 20 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Alamo N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Ray

13. Birthplace Union S. C.

MOTHER 14. Maiden Name Lillie Gray

15. Birthplace Lawrence S. C.

16 (a) Informant William Ray.

(b) Address 700 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location A. A. Co. Md.

18 (a) Funeral director Belmont Francis H. Knight

(b) Address 721 Asquith St

19 (d) MAR 22 1945 (Date received by registrar)

Registrar Huntington Hillsdale, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1945, at 3 38 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-1 1945 to 3-19 1945 and that I last saw h— alive on 3-19 1945.

Immediate cause of death Pulmonary Edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
19 Dys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. D. Hatcher M. D.

Address 1 W Pratt Date signed 3/19/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G27132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Eutaw Place (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Willis James Crouch

3 (b) If veteran, name war

3 (c) Social Security Account No. 450-24-3793

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1902

8. AGE: Years	Months	Days	If less than one day
42 43	4	20	....hr. ....min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Crouch
(b) Address 1917 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) [illegible] (b) MAR 22 1945 Registrar
Huntington Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 8:15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage

Due to Linear fracture of Skull.

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/12/45 at 14/1 P. M.
(b) Where did injury occur? 1925 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Fell down steps

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 21, 1945

X

G27133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1799

G27133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 951 Etting St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Lena Oliver

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. , 1878

8. AGE: Years	Months	Days	If less than one day
66	4		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Wesley Oliver
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Bernard Oliver
(b) Address 951 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Hahlo & Son
(b) Address

19 (a) (Date received by registrar) MAR 22 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1945, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gangrenous Esophagitis and gastritis

Due to Ingestion of Lye

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 11 1945 P. M. 17 1
(b) Where did injury occur? 951 Etting St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Swallowed Lye

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 22 1945

X X

627134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

627134 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Parkaw
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Parkaw (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret McLean Hanson

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 9 1865

8. AGE: Years 79 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Percy W. Hanson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Stopper
15. Birthplace Maryland

16 (a) Informant Mrs Paul Heathcote (sister)
(b) Address 1309 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart Mortuary
(b) Address 1600 W. North Ave.

19 (a) MAR 22 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 March 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938 to 21 March 45.
and that I last saw h[illegible] alive on 21 March 1945.

Immediate cause of death: Cerebral hemorrhage — Duration
Due to: Arteriosclerosis
Due to: —
Other Conditions: None
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 712 Park Ave — Date signed M. 22 August D. 1945

Huntington Williams, M.D.

Dr. Feinglos
2002 E. Pratt St.
G27135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G27135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5508 Morello Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5508 Morello Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie T. Johnston

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William F. Johnston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1863

8. AGE: Years	Months	Days	If less than one day
82	---	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. William F. Johnston
(b) Address 5508 Morello Road, #14

17 (a) Burial (b) Date thereof 3/23/34
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar) Registrar
MAR 22 1945 Huntington Williams, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to March 20 1945
and that I last saw alive on March 19 1945.

Immediate cause of death: Acute Uraemia, Cause — Duration 2 days
Due to Chr. Nephritis & Hypertension — 7
Due to Arteriosclerosis — .
Other Conditions Bronchopneumonia, Left Chest — 4 yrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Feinglos M. D.
Address 2002 E. Pratt St. Date signed 3/22/45

1310

G27136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27136 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1076 Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1076 Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Steet.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: ~~Single~~ married

6 (b) Name of husband or wife: MARIE TANNER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unk.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Rhodes
(b) Address 1102 W. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 23 '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) MAR 22 1945 ...ington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1945 at 1150 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1945 to 3/20 1945 and that I last saw h. alive on 3/19 1945

Immediate cause of death: Cardiac Renal — Duration: 4 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Hazlett M.D.

Address 1125 Park Ave. Date signed 3/21/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

LOFTON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27137 / 93E — Registered No. G27137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Vine
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Lofton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10 - 1886

8. AGE: Years: 59 | Months | Days | If less than one day: hr. min.

9. Birthplace Burgaw, N.C.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Jeff. Larkins
13. Birthplace N.C.

MOTHER
14. Maiden Name Hester Moore
15. Birthplace Burgaw, N.C.

16 (a) Informant Mrs. Lella Watford
(b) Address 929 Vine St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar. 23 45 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Burgaw N. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 22 1945 (Date rec'd by Reg.) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1945 to March 19 1945. and that I last saw h[illegible] alive on March 19 1945.

Immediate cause of death: Myocarditis — Duration: 6 Months

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3-22-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

G27138

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 75B

G27138
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Arnold
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin J. Smith (Edwin John Smith)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1923

8. AGE: Years	Months	Days	If less than one day
21 ~~22~~	11	13	— hr. — min.

9. Birthplace Md Arnold, Md.
(Town, county and state)

10. Usual Occupation pipe fitter's helper

11. Industry or business U. S. Naval Academy

FATHER
12. Name Albert G. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn Sheeler
15. Birthplace Md New York

16 (a) Informant Father
(b) Address Arnold Md.

17 (a) Burial (b) Date thereof March 25, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arnold Church Yd Cem
Location Md. Arnold Md.

18 (a) Funeral director Miles Lawrence
(b) Address 1003 W. Baltimore St.

19 (a) MAR 22 1945 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1945 to 3-22 1945 and that I last saw him alive on 3-22 1945.

Immediate cause of death	Duration
Acute peritonitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-21-45

Major findings of operation: Acute peritonitis

of autopsy: ~~Enlarged spleen, cirrhosis of liver, chronic~~ ~~interstitial nephritis, arteriosclerosis~~

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K M Browne M. D.
Univ. Hosp. Date signed 3-22-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

27139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JO #90596

Registered No. G27139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Harford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Sadie Rose Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Russell Owens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1917

8. AGE: Years 27 | Months -9- | Days 28 | If less than one day hr. min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Richard Petty
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Anne Glenn
15. Birthplace: South Carolina

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-1945 (month) (day) (year)
(c) Cemetery or crematory
Location: Cappeny, L. C.

18 (a) Funeral director: Mrs. Lizzie A. Strickland
(b) Address: 1631 Druid Hill Ave.

19 (a) 3-2-1945 (Registered by Registrar) (b) Huntington Williams, M.D.

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1944 to Mar. 19, 1945 and that I last saw h.er alive on Mar. 19, 1945.

Immediate cause of death: Pulmonary tuberculosis bilateral — Duration: 1 yr.

Due to:

Due to:

Other Conditions: Rheumatic heart disease. (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harold Dalton M. D.

Address: Balto. City Hosp. Date signed 3/20/45

140

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 107

Registered No. G27140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Ft. Meade (If outside city or town limits, write RURAL and give town)
(d) Street No. Regional Hospital (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Marshall Harvey Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-19-44

8. AGE: Years	Months	Days	If less than one day
[illegible]	5	1	hr. ..... min.

9. Birthplace Nebraska (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Marvin H. Scott
13. Birthplace Nebraska

MOTHER
14. Maiden Name La Vere Zimmerman
15. Birthplace Nebraska

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-45 (month) (day) (year)
(c) Cemetery or crematory Aurora Cemetery
Location Aurora, Nebr.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

MAR 22 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945, at 5.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 19 45 to March 20 45 and that I last saw h[illegible] alive on March 20 45

Immediate cause of death ? anaphylactic shock — Duration .....
Due to ?? capillary bronchitis .....
Due to ....
Other Conditions Eczema .....
(Include pregnancy within 3 months of death) .....
Date of operation.....
Major findings of operation:.....
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature John R. Birmingham M.D.
Address..... Date signed 3-21-45

JHH

correct age is especially important. Physicians: please write the

VS 150

G27141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183a

G27141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cabell & Saratoga
(c) Hospital or institution:
Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 N. Wolfe St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE KALUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Kalus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/1880

8. AGE: Years	Months	Days	If less than one day
65		23	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Conrad
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Josephine Behensky
15. Birthplace Czechoslovakia

16 (a) Informant Mr. August Kalus
(b) Address 1924 Bounds Ave.

17 (a) Buried (b) Date thereof 3-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Roach Brothers
(b) Address 900 W. Chester St
(Interington Williams M.D.)

MAR 22 1945 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/1945 at 7:57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19/1945 to 3/21/1945 and that I last saw her alive on 3/21/1945

Immediate cause of death Congest. Heart Failure. — Duration

Due to Cerebral Vascular accident — Duration

Due to Hypertension — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. T. Spalding M. D.
Address Mercy Hosp. Date signed 3/22/45

VS 150

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G27142 Homburg G27142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Commonwealth Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town) Connecticut Ave
(d) Street No. 4203 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katherine F Homburg.

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Widowed

6 (b) Name of husband or wife Ernest Homburg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1862

8. AGE: Years	Months	Days	If less than one day
82	10	5	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business House work

FATHER 12. Name John Shea.
13. Birthplace

MOTHER 14. Maiden Name Ellen O'Connell
15. Birthplace Ireland

16 (a) Informant Mrs. Helen Tavanello
(b) Address 4203 Commonwealth

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore - Md.

18 (a) Funeral director Edgar L. MacGabe
(b) Address Catonsville Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1944, to 3/20 1945, and that I last saw h alive on 3/20 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cardio-Vascular Disease & Hypertension	9 years
Due to	
Other Conditions Anemia Pernicious type (Include pregnancy within 3 months of death)	3 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W Johnson M. D.
Address 3452 Dudley Ave Date signed 3/21/45

G27143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G27143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie J. West

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1900

8. AGE: Years	Months	Days	If less than one day
44	2	26	hr. min.

9. Birthplace Halifax Co., Va.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John M. West
13. Birthplace Halifax Co., Va.

MOTHER
14. Maiden Name Lelia Jennings
15. Birthplace Halifax Co., Va.

16 (a) Informant Mr. John M. West
(b) Address Clarkton, Halifax Co., Va.

17 (a) Removal (b) Date thereof 3/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Brookneal, Campbell Co., Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 23 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 13 1945 8 30 P M.
(b) Where did injury occur? 812 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Restaurant While at work? No
(d) Means of injury Fell down stairs

23. Signature Robert Lee Fratcher M.D.
Medical Examiner.
Date signed March 22 1945

VS 151

G27144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G27144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 E 35th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E 35th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene Tawney

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1867

8. AGE: Years 77 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business C-AR

FATHER 12. Name Thomas A Tawney
13. Birthplace Md

MOTHER 14. Maiden Name Mary Murrayman
15. Birthplace Md

16 (a) Informant Mrs Hubert Smith
(b) Address 533 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilhelm Corp
(b) Address 1217 E Pratt St

MAR 23 1945 (Date received by local registrar) Director for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to 3-21 1945 and that I last saw h alive on 3-20 1945

Immediate cause of death Chronic myocarditis — Duration 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Gordy M.D.

Address 5706 Harford Rd Date signed 3/21/45

VS 150

Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

Registered No. G27145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 East 22nd St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William David Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nora E. Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1876

8. AGE: Years 68 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None - Retired

11. Industry or business

FATHER
12. Name William D. Harris
13. Birthplace Va

MOTHER
14. Maiden Name Isabelle (Pemberton)
15. Birthplace Va

16 (a) Informant Mrs. Nora Edith Harris
(b) Address 208 East 22nd St.

17 (a) Burial (b) Date thereof 3/23/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 MAR 22 1945 (b) Huntington Wilkins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20- 1945 at 9:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1945 to 3-20- 1945 and that I last saw him alive on 3-20- 1945

	Duration
Immediate cause of death Cardiac Failure	
Due to Arteriosclerotic Cardiovascular disease	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Cornue M. D.
Address Union Memorial Hospital Date signed 3-20-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 627146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. of A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Hummelstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerard E Betts

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 091-01-8372

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Opal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1898

8. AGE: Years 46 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Iona (Town, county, and state)

10. Usual Occupation Mgr. Parts Accessories

11. Industry or business Chevrolet Motor Div

FATHER 12. Name Jerry E Betts

13. Birthplace Iona

MOTHER 14. Maiden Name Cora Mains

15. Birthplace Iona

16 (a) Informant Mrs Opal E Betts

(b) Address Hummelstown Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/45 (month) (day) (year)

(c) Cemetery or crematory Hershey

Location Hershey Pa

18 (a) Funeral director Milton Croft Inc

(b) Address 1219 Penn St

19 MAR 23 1945 (Date rec'd by registrar) Registrar for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 1 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Graham M.D.
Medical Examiner.
Date signed March 22 1945

VS 151

62747 ✓ 62747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1367 Montpelier Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 61
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1367 Montpelier Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Starks (Stokes)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-1909

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —

6 (a) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-1897

8. AGE: Years	Months	Days	If less than one day
47	11	26	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Thomas Starks
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant James Starks
(b) Address 631 N. Carey St.

17 (a) Burial (b) Date thereof 3-23-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) Harrington for Wilkinson
(Date rec'd by registrar) (Registrar)
MAR 23 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-1945; at 9:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Lymphoid Leukemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mascis M.D.
Medical Examiner.
Date signed 3-13-45

X

627148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

627148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Fleet St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Stein (or) Wojtas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1892

8. AGE: Years	Months	Days	If less than one day
52	8	16	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business —

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Anna McCrahen
(b) Address 2614 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Fialkowski
(b) Address 1020 S. Kenwood Ave.

19 (a) Date received MAR 23 1945 (b) Huntington Williams, M.D. Registrar

VS.151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945, at 11 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Hypertensive cardiovascular disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 21 1945

7149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 61

Registered No. G-7149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1860

8. AGE: Years 84 | Months 6 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Bel Air, Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Alice Harris
(b) Address 1344 Druid Hill Ave.

17 (a) Burial (b) Date thereof 3.23.45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md.

18 (a) Funeral director Thos. Lee & Holland
(b) Address 1601 Druid Hill Ave

MAR 23 1945 (Date rec'd by registrar) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1945, at 8:18 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Appx. Jan 1942 to Mar. 1945, and that I last saw h.... alive on Appx. Dec. 1944.

Immediate cause of death Chronic Nephritis — Duration 10 yrs. +

Due to

Due to

Other Conditions Hypertension. Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Murray Fisher M.D.
Address 18 E. Eager St. Baltimore Md. Date signed 3/24/45

1318

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 627150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 N Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Emma Sutton

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1879

8. AGE: Years 65 | Months 2 | Days 19 | If less than one day 23 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Nelson Sutton

13. Birthplace Baltimore

MOTHER 14. Maiden Name Louise Kemp

15. Birthplace Baltimore

16 (a) Informant Emma Sutton

(b) Address 809 N Castle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26/45 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto Md

18 (a) Funeral director Wilkes Funeral Home

(b) Address 2008 Orleans St

19 MAR 23 1945 by Hunting for Williams M.F. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sick Mo. 1940, to Sick Mo. 1941, and that I last saw him alive on March 21 1945.

Immediate cause of death	Duration
Acute Coronary Thrombosis	-
Due to Coronary Artery Disease	-
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Linard Brill M. D.

Address 826 N. Washington St. Date signed March 23 1945

VS 150

G27151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G27151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 Hull St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 Hull St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Blanche A. Duffey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas. Duffey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	4	hr. min.

9. Birthplace New Orleans, La.
(Town, county, and state)

10. Usual Occupation housework.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Angus Bordeau
(b) Address 1433 Hull St.

17 (a) burial (b) Date thereof 3-23-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director Chas. F. Dill
(b) Address 507 E. Fort Ave.

MAR 23 1945 Huntington Williams, M.D.
(Local city or county registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1944 to 3-21 1945.
and that I last saw h[illegible] alive on 3-21 1945.

Immediate cause of death Chronic Myocardial Degeneration — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Collod M. D.
Address 707 E. Fort Ave. Date signed 3-21-45

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

627152

627152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 627152

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age in years, especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4014 Penhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4014 Penhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith Natalie Keefer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or ~~wife~~ McClellan Keefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1889

8. AGE: Years 55 | Months 6 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Uniontown, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Nathan Haines
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Stultz
15. Birthplace Md.

16 (a) Informant Mrs. Paul E. Selby
(b) Address 4014 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Union Bridge, Carroll Co., Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) MAR 23 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 9.45

20. DATE OF DEATH March 22, 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1944, to March 22 1945, and that I last saw h[er] alive on March 21 1945.

Immediate cause of death: Carcinoma left breast — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Oct. 22, 1944
Major findings of operation: Carcinoma left breast with metastasis to sternum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 3703 Fairmount Blvd. Date signed 3/23/45

VS 199

G27153

JO #91198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G27153

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: BALTIMORE CITY HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-D 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 504 N? Arlington Ave (If rural give location)

(e) Citizen of foreign country No (Yes or No)

If yes, name country

3 (a) FULL NAME: Jerry Davis

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucinda

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 9/4/1880

8. AGE: Years 64 | Months 6 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual Occupation: Railroad Worker

11. Industry or business:

FATHER

12. Name: Henry Davis

13. Birthplace: S.C.

MOTHER

14. Maiden Name: Rachael ?

15. Birthplace: S.C.

16 (a) Informant: Hospital Records

(b) Address: 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Mem'l. Pk

Location: Balto. County

18 (a) Funeral director: Charles G. Cooper

(b) Address: 512 N. Carrollton Ave

19 (a) MAR 23 1945 (b) Registrar's signature: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 11:5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1944, to Mar. 19 1945, and that I last saw him alive on Mar. 19 1945.

Immediate cause of death	Duration
Broncho pneumonia	3 days
Due to C.A. Prostate	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-3-45

Major findings of operation: Bladder Calculi, Bladder tumor

of autopsy: Broncho pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Perry M.D.

Address B.C.H. Date signed 3/24/45

X

PERSON WHO FILLS OUT, WITH DIAGNOSIS, ENTRIES ON THIS CERTIFICATE should be careful to see that every item of information is correct and complete. Omission of age is especially important. Physicians: please write the causes of death clearly and legibly.

67154
CWK 92479

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

91a

Registered No. 67154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54-9-21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Sharp Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Leroy Robert Handy.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 29. 1890

8. AGE: Years	Months	Days	If less than one day
54	9	21	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Handy
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Johnson
15. Birthplace Md.

16 (a) Informant Balto. City Hospital-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1330 Brantley Ave.

19 (a) MAR 23 1945 (b) Interred for Millington Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9/1945 to 3/20/1945 and that I last saw him alive on 3/20/1945.

Immediate cause of death	Duration
Cardiac failure	?
Due to Subacute bacterial endocarditis	16 days
Due to	
Other Conditions Edema and acute infection	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 3-20-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G27155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5-1-B

Registered No. G27155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Schmid

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-3423

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Matilda M. Schmid

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1883

8. AGE: Years 61 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace New York City N.Y.
(Town, county, and state)

10. Usual Occupation Watchmaker

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. John W. Schmid
(b) Address 6318 Wheeler St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Moriah Cemetery
Location S.W. Phila. Pa.

18 (a) Funeral director Edgar H. Conklin & Son
(b) Address 924 E. Eager St. Balto. Md.

19 (a) MAR 26 1945 (b) (Date rec'd by Registrar) Thomas [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1945 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12/44 19 to 3/22/45 19, and that I last saw h[illegible] alive on 3/22 19 45.

Immediate cause of death Cardio-Resp. Failure - Cardiac Decompensation
Terminal Pneumonia — Duration

Due to Cardio-Ca Dorsal Spine Metastatic

Due to Possible Primary Ca of Prostate

Other Conditions Poss. Ca of Thyroid

(Include pregnancy within 3 months of death)

Date of operation 4/12/44

Major findings of operations: Extra Dural Metastatic Ca

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury
(e) Signature Robert McFadden M. D.
Address St Joseph's Date signed 3/22/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G27156

DERNBERGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27156

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balto. Gen'l Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1659 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred J. Dernberger
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26 1875

8. AGE: Years	Months	Days	If less than one day
69	10	26	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Carnival Operator
11. Industry or business

FATHER
12. Name Adam Dernberger
13. Birthplace N.Y.

MOTHER
14. Maiden Name Louise Weltus
15. Birthplace N.Y.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/23/45 (month) (day) (year)
(c) Cemetery or crematory
Location Cleveland, O.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.
(c) Huntingtown Williams, Md.

MAR 23 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/45 at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/45 to 3/22/45.
and that I last saw him alive on 3/21/45

Immediate cause of death	Duration
Coronary Arteriosclerosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Gassaway
Address S. Balto Gen Hosp Date signed 3/23/45

VS 150

627157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. 627157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Berry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Atkinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-0986

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1901

8. AGE: Years 43 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Meat Store

FATHER
12. Name James Atkinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Bessie Harmon
15. Birthplace Maryland

16 (a) Informant Mrs. Nellie Stevens
(b) Address 624 Berry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran
Location Catonsville

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615 Chestnut Avenue

19 (a) Date rec'd by local reg. MAR 27 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945, at 5:45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of the Liver.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed March 23, 1945.

VS 151

C27158

CWK-73651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C27158

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 10- 20
(e) Length of stay in Baltimore (yrs., mos., or days) 72- 1- 21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 W. 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Caltrider,

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29-1873

8. AGE: Years	Months	Days	If less than one day
72	1	21	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Caltrider (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Priscilla Bailey
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof May 24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Ehrenfeld & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Filed by registrar) (b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th, 1945 at 3.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1942 to Mar. 20 1945 and that I last saw him alive on 3-20-45

Immediate cause of death	Duration
Bronchopneumonia	2 Days
Due to	
Due to	
Other Conditions fracture neck of femur 18 Days; Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Bronchpneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3-3-45 at ? P. M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Balt. City Infirmary While at work? no
(Specify type of place)
(e) Means of injury Fell down

23. Signature Hauck C. Bolton M. D.
Address Balt. City Hosp. Date signed 3/22/45

Approved by Howard J. Andrews, M.D.

67159 ✓ 67159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Lehigh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Lehigh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Sarloff.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harold Sarloff.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11 1880

8. AGE: Years 64. | Months 8 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore County.
(Town, county, and state)

10. Usual Occupation
11. Industry or business House-Wife

FATHER
12. Name Henry Rickert.
13. Birthplace Baltimore County.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore County.

16 (a) Informant Harold Sarloff
(b) Address 311 S. Lehigh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20 1945
(month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave.

18 (a) Funeral director Wendell J. Hysel
(b) Address 312 S. Highland Ave

19 (a) (b)
(Date rec'd by registrar) MAR 23 1945 Registrar

VS 10m

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1945 to 3/18 1945
and that I last saw h Ed alive on 3/17 1945

Immediate cause of death Bronchopneumonia — Duration 1 wk.
Due to Myocarditis Chronic Disease — 1 wk.
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Nicholas F. Mantomoli M. D.
Address 1076 S Eastern Ave Date signed 3/19/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G27160 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 S Highland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S. Highland ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William. Long

3 (b) If veteran, name war: First World war.
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: White.
6 (a) Single, married, widowed, or divorced: Divorced.
6 (b) Name of husband or wife: Jeanette
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 2. 1891.
8. AGE: Years 53. Months 11 Days 20 If less than one day: hr. min.
9. Birthplace: Baltimore City. (Town, county, and state)
10. Usual Occupation: Weigh. Master
11. Industry or business: Cotton Company

FATHER
12. Name: Casper. Long.
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Elizabeth K. Smith.
15. Birthplace: Baltimore County.

16 (a) Informant: Casper Long
(b) Address: 709 S. Highland ave
17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Mar. 24. 1945 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn.
Location: Easton. ave.
18 (a) Funeral director: Wendell. Hippel
(b) Address: 312. S. Highland ave.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1945 at 4.00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to March 22 1945 and that I last saw h[illegible] alive on March 21 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Eg Schumacher M. D.
Address 842 S. East Ave. Date signed 3-22-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 MAR 23 1945 Huntington Williams, M.D.

627161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B 627161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d o a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Musumeci

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 19 1887

8. AGE: Years	Months	Days	If less than one day
67		3	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Relief

11. Industry or business

FATHER
12. Name Joseph Musumeci
13. Birthplace Italy

MOTHER
14. Maiden Name Miss Vitta
15. Birthplace 316 S. Eden St

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof March 24 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Kendall J. Dippel
(b) Address 312 S. Highland Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 1.35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 22 1945

7162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

Registered No. 627162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 E 24th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 E. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E Durbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: William Durbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 Months Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic Work

11. Industry or business —

FATHER
12. Name James Barrett
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Peter Williams
(b) Address 413 E 24th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, L. I., N. Y.

18 (a) Funeral director Ida Bailey
(b) Address 1421 E. Jefferson St.

19 (a) MAR 23 1945 (Date received by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to March 1945 and that I last saw h[illegible] alive on March 22 1945

Immediate cause of death: Pneumonia (acute lobar) due to Cerebral Hemorrhage

Due to: Hypertension and Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: For 2 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emerson R Julian, M.D.

Address 434 E. 23rd Date signed 3/27/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

627163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

✓ 627163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Chapel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Millard Holland
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 5- 1884

8. AGE: Years	Months	Days	If less than one day
60	5	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name William A. Snow
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Millard Holland
(b) Address 225 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Flippo & Fleming
(b) Address 1426 Light St.

19 MAR 23 1945 (Date received by Registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH March 23, 1945 at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest
Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-21-45 at 5- 6/4 P M.
(b) Where did injury occur? Orleans & Washington Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Frater M.D. (Medical Examiner)
Date signed March 23 1945

VS 151

G27164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27164 Registered No.

No. 91350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 18
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 East Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5th, ? 1874

8. AGE: Years 70 ? | Months 11 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace California
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Ritter
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Dunnan
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) ... (b) Date thereof ...
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location ... MAR 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) MAR 24 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945 19... at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30-44 19... to 3-18-45 19..., and that I last saw h im alive on Mar. 18 19 45

Immediate cause of death coronary occlusion ?

Duration ?

Due to

Due to

Other Conditions hypertensive cardiovascular disease; uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. C. Lang, Jr. M. D.
Address City Hosp. Date signed 3-22-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

2596

627165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

627165 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in years, months, days, hours, or minutes. Use no abbreviations.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Cadley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-3
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Cadley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catharine Angela O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~or wife~~ Thomas O'Brien
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 26 - 1888

8. AGE: Years	Months	Days	If less than one day
56	9	24	hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)
10. Usual Occupation Domestic wife
11. Industry or business

FATHER
12. Name George Pepperman
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elizabeth Bellemann
15. Birthplace Germany

16 (a) Informant Catharine E Anderson
(b) Address 1332 Poplar Ave. Arbutus

17 (a) Burial (b) Date thereof March 26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. A. A. Co.
Location

18 (a) Funeral director Bernard C. Hartz
(b) Address 121 E West St

19 (a) MAR 24 1945 (b) Huntington Williams Md
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 - 1945 at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 8 1945 to March 22 1945 and that I last saw h[illegible] alive on March 17-1945

Immediate cause of death	Duration
Angina Pectoris	1 year.
Due to	
Due to	
Other Conditions Hypertension Multiform	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Ruland
Address 2532 Edmondson Ave Date signed 3-22-45 M. D.

94C

627166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 627166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 Wheeler Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 16 Wheeler Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Treulieb

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-05-3483

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. White, Married

6 (b) Name of husband or wife: Anna C. Mesmeringer

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1890

8. AGE: Years 54 | Months 4 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Supervisor

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: William Treulieb
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth Brouer
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs Anna C. Treulieb
(b) Address: 16 Wheeler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn P.O., Md.

18 (a) Funeral director: Frederick A. Dole
(b) Address: 1200 W. Lombard St

19 (a) MAR 24 1945 (Date received by registrar) Huntington Wilson, Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1945, to 3/21 1945, and that I last saw him, alive on Mar 21 1945.

Immediate cause of death: Coronary Sclerosis — Duration: ?

Due to: Arteriosclerotic Hypertensive Cardiovascular Disease — Duration: ?

Due to: — Duration:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature: Carl E. Roesling M. D.
Address 1226 W. Lombard St Date signed 3/24/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

G27167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27167 Registered No. 1572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 Beryl Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Beryl Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Wm. Tochterman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1939

8. AGE: Years	Months	Days	If less than one day
6 yrs.	-	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name James Alfonso Tochterman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth C. Smith
15. Birthplace Baltimore, Md.

16 (a) Informant mother
(b) Address 2627 Beryl Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery or ~~CEMETERY~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1945 at 10.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 at Seen Alive 19; and that I last saw h alive on 19.

Immediate cause of death: Pulmonary Edema

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Pulmonary Edema-congestion, Enlarged Tonsils, Acute Splenic tumor

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Brown M.D.
Address Date signed 3/24

Approved: Robert Lee Slaton Sinai Hosp. M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G27168 — Registered No. G27168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Chilton ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Columbia F. Pilsch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Jacob Pilsch
(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan 9-1882

8. AGE: Years	Months	Days	If less than one day
63	2	17	hr. min.

9. Birthplace Washington DC.
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name John R. Colvin
13. Birthplace Warrenton Va.

MOTHER
14. Maiden Name Fannie Moore
15. Birthplace —

16 (a) Informant Jacob Pilsch
(b) Address 1616 Chilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Maryland

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver Street

19 (a) MAR 24 1945 (b) Thurlington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1945 at 12 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1945 to 3-23 1945 and that I last saw her alive on 3-23 1945.

Immediate cause of death	Duration
Carcinoma of Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hosp Date signed 3-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

27169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G27169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flet St
(c) Hospital or institution: 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Mulliken St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ulysses Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1892

8. AGE: Years	Months	Days	If less than one day
53	-	19	hr. min.

9. Birthplace Eastern Shore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Martha Young
(b) Address 1421 Mulliken Ct Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert O. Elliott Sr.
(b) Address 1129 N. Caroline St

MAR 2 1 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned
Probably Accident

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found March 23 3/2 1945 8 A.M.
(b) Where did injury occur? Harbor foot of Central Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Found Drowned

23. Signature Robert O. Gruber M.D.
Medical Examiner.
Date signed March 23 1945

VS 151

G27170

CWK-92649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

127B

G27170 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Years

17-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 559 Oxford Street
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME
Clem Yancy.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Sallie Yancy
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 5-1875

8. AGE: Years	Months	Days	If less than one day
70	2	16	.....hr. .....min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Watson Yancy. (D)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Martha Watkins. (D)
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Mar 26, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Arbutus - Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) ..... (b) E. Huntington Williams M.D.
(Date rec'd by registrar) MAR 24 1945 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21st 1945, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19- 1945, to 3-21 1945 and that I last saw h[illegible] alive on 3-21 1945

Immediate cause of death	Duration
Pneumonia	
Due to Gangrene of Gallbladder	
c Peritonitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3-19-45
Major findings of operation: As above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature E. H. Cutler M. D.
Address City Hospitals Date signed 3-23-45

G27171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27171 / 93D

Registered No. G27171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4920 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4920 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Crowder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louisa Knox Crowder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/71

8. AGE: Years	Months	Days	If less than one day
74	1	3	hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual Occupation Retired farmer

11. Industry or business

FATHER
12. Name Fredk. Crowder
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. W G. Crowder
(b) Address 4920 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 26 42 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Balto. Co. Md

18 (a) Funeral director Lannahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received by Registrar) MAR 24 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1942, at 12 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to 3/23 1942, and that I last saw him alive on 3/23 1942

Immediate cause of death	Duration
Hypostatic Pneumonia	
Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions Cerebral Hemorrhage (Include pregnancy within 3 months of death)	1 day

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huston Tolley M. D.
Address 5703 Harford Rd Date signed 3/23/42

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARY NIKol

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 7172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Nikol

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Peter J. Nikol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10 1892

8. AGE: Years	Months	Days	If less than one day
52	3	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name William Robel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Baltimore Md

16 (a) Informant Miss Elizabeth M. Nikol
(b) Address 1422 N Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Belair Rd

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 MAR 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-45 19 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1945 to 3-22 1945 and that I last saw her alive on 3-22 1945

Immediate cause of death Asphyxiation

	Duration
Due to aspiration of vomitus ?	
Due to	
Other Conditions Carcinoma - Lobular type multiple metastases, Cachexia	2 yrs

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: multiple carcinoma metastases

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Gleason M. D.
Address Univ Hosp Date signed 3-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G27173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G27173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Homewood Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Homewood Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine T. Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-6028

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced.~~ Single

6 (b) Name of ~~husband or wife~~

6 (a) ~~If alive, give age~~ years

7. Birth date of deceased (mo., day, yr.) Sept 16-1873

8. AGE: Years 71 | Months 6 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Timothy Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Mooney
15. Birthplace Ireland

16 (a) Informant Hannah E. Feihe
(b) Address 1915 Homewood Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director John G. Mosman
(b) Address 3000 E Baltimore St

19 (a) MAR 24 1945 (b) Registered by Wallace Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 at 6:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1945 to March 23 1945 and that I last saw her alive on March 22 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 7 days

Due to Cardio vascular renal disease — Duration 9 ?

Due to

Other Conditions Cystitis. Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? — — — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Harvey Hyde M.D.
Address 1100 E Northern Pkwy Date signed 3/26/45

X

correct age is especially important. Physicians: please write the

G27174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G27174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 238 Wilson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 238 Wilson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lulu A. B. Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	Widowed

6 (b) Name of husband or wife Thomas Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) march 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	-	8	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Tom Jackson
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Patrick Jackson
(b) Address 238 Wilson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus cem.
Location md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Presstman St

MAR 24 1945

(b) Interington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH march 23 1945, at 3.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1939 to Mch 23 1945 and that I last saw h. alive on Mar 22 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 yrs
Due to Hypertensive Cardiac	4
Due to Disease	

Other Conditions Peralysis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 1431 W Franklin Date signed 3/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G27175

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 Wilson ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Wilson ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	colored	married

6 (b) Name of husband or wife Anna Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 22, 1902

8. AGE: Years	Months	Days	If less than one day
42	7	1	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John Harris
13. Birthplace md

MOTHER
14. Maiden Name Lillie Wright
15. Birthplace md

16 (a) Informant Myrtle Taylor
(b) Address 531 Wilson ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H Kelson
(b) Address 1303 Pennsylvania ST

19 (a) MAR 24 1945 (Date rec'd by registrar) (b) by Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH march 23 1945, at 1.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4-1944 to 3-23 1945 and that I last saw h alive on 3-15-1945.

Immediate cause of death Pulmonary Tuberculosis — Duration —

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Deem Hom M. D.
Address 1207 Carlton ST Date signed 3/24/45

VS 160

G27176 LEONARD IRETON BAKER G27176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 235 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1909

8. AGE: Years 35 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, County, and State)

10. Usual Occupation Factory Collector

11. Industry or business Balto. City

FATHER 12. Name Joseph Baker

13. Birthplace Md.

MOTHER 14. Maiden Name Loretta Barker

15. Birthplace Md.

16 (a) Informant Leonard Baker

(b) Address 225 S. Stricker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick

18 (a) Funeral director Geo. J. Kenny

(b) Address Holland & Belmont

19 (a) MAR 24 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 19 45, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 19 45, to 3/23 19 45, and that I last saw h[illegible] alive on 3/23 19 45

Immediate cause of death Septicemia

Bacterial endocarditis.

Due to

Due to

Other Conditions Carcinoma of the Liver.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy Subacute B.E. & cirrhosis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers, M.D.

Address Franklin Sq. Hosp. Date signed 3/23/45

91a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6-7177

6-7177 / 472

Please write the causes of death clearly and legibly. Physicians: please write information in ink. Every question should be carefully answered. Where the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Loren Memorial Hosp.
(c) Hospital or institution: 1301 Woodbourne Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Woodbourne ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE McINTYRE ROBERTSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/2/857

8. AGE: Years 68 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Supt. of Children's Home

11. Industry or business

FATHER
12. Name James Robertson
13. Birthplace New York

MOTHER
14. Maiden Name Emma Sellers
15. Birthplace Pennsylvania

16 (a) Informant Sister Jessie of Dn Saints
(b) Address Sr. Gabriel's Home, Catons

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 27 46 (month) (day) (year)
(c) Cemetery or crematory St Davids Cemetery
Location Radnor Pa

18 (a) Funeral director John P. Mitchell, Hons
(b) Address 1900 Eutaw Place

19 (a) Date received by local registrar MAR 24 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1945, to March 24 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
C.V.R failure (Cardio-vascular)	
Due to Carcinomatosis (Carcinoma of lung & mets)	
Due to Also hypertensive cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W L Dunnell M. D.
Address Union Mem. Hosp. Date signed 3/24/45

VS 150

G27178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77C

Registered No. G27178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth M. Haintz

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. H. Haintz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3. 1905

8. AGE: Years	Months	Days	If less than one day
37	2	21	hr. min.

9. Birthplace New Rochelle, N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Louis Salvenbert.
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Glab
15. Birthplace New Rochelle, N. Y.

16 (a) Informant Wm. H. Haintz
(b) Address 527 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26 1945 (month) (day) (year)
(c) Cemetery or crematory Location New Rochelle N. York

18 (a) Funeral director Ralph C. B. M. Walters
(b) Address Pratt & Stricker Sts

19 MAR 24 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 5:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert C. Graham M.D. Medical Examiner.
Date signed 3-24-45

G27179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G27179 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Baltimore St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME Samuel Booker

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Date Known
8. AGE: Years 63(?) Months Days If less than one day hr. min.
9. Birthplace Amelia County Virginia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Samuel Booker
13. Birthplace Amelia County Virginia

MOTHER
14. Maiden Name Judy —
15. Birthplace Amelia County Virginia

16 (a) Informant Isaiah Claiborne
(b) Address 420 N. Dallas Street.

17 (a) Burial (b) Date thereof Mar. 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Amelia, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) MAR 24 1945 (b) Huntington Williams, M.D.
(Date received by local registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1945 to March 22 1945, and that I last saw him alive on Mar. 21 1945.

Immediate cause of death Arteria sclerotic heart Disease — Duration

Due to Arteria sclerotic heart Disease

Due to

Other Conditions Old Age

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Patchen M. D.
Address 1225 Penna Ave Date signed 3/24/45

27130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 27130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Galloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lula Galloway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1882

8. AGE: Years	Months	Days	If less than one day
62 63	8	22	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name James Galloway
13. Birthplace md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lula Galloway
(b) Address 606 N. Bond St

17 (a) Burial (b) Date thereof Mar. 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave

19 (a) MAR 24 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 7:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-22-45 at 1:10 A. M. 7/5
(b) Where did injury occur? Monument & Caroline Sts
(c) Did injury occur in home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 3-22-45

VS 151

G27181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120

Registered No. G67181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive and 31st St.
(c) Hospital or institution: US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Foxwell (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLARD RALPH HINSON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife: Richie Ingram
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1910

8. AGE: Years	Months	Days	If less than one day
35	0	3 20	hr. min.

9. Birthplace: Foxell, Virginia (Town, county, and state)
10. Usual Occupation: Captain
11. Industry or business: Seafaring

FATHER
12. Name: Willie H. Hinson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mollie Crandell
15. Birthplace: Virginia

16 (a) Informant: Records-US Marine Hospital
(b) Address: Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 1945 (month) (day) (year)
(c) Cemetery or crematory
Location: Kilmarnock Va.

18 (a) Funeral director: Harry H. Amacost
(b) Address: 4204 Ridgewood Ave
25 1945
Registrar: Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1945 at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21, 1945 to Mar. 23 1945, and that I last saw him alive on Mar. 23, 1945

Immediate cause of death	Duration
Pulmonary tuberculosis, far advanced bilateral	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W J Jones M. D.
Address: US Marine Hospital, Baltimore, Md. Date signed 3/24/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27182

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

61

Registered No. G27182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Harford
(a) State Md. (b) County Baltimore
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emmerton Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Alice Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1872

8. AGE: Years	Months	Days	If less than one day
72	4	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Abel Durham
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Lowe
15. Birthplace Maryland

16 (a) Informant Mrs Earl Schelling
(b) Address Rocks Md

17 (a) Burial (b) Date thereof March 27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oldbrook Baptist
Location Jerrettsville Md

18 (a) Funeral director Martin G Hunt
(b) Address Jarrettsville Md.

19 (a) 3-28-45 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945 at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26, 1945 to March 23 1945, and that I last saw her alive on March 23 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Generalized Arterio-sclerosis	
Due to Diabetes mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C. Hutchinson

Address 206 E. 34th St. Date signed 3-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G27183 ✓ G27183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. 2183

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important. Typewriting is preferred.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1409 N. Carey St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 d

(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5306 Hamlet Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Margaret Seeberger ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Conrad Seeberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/1865

8. AGE: Years 80 Months 1 Days 14 If less than one day hr. min.

9. Birthplace Baltimore — Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Nicholas Gromann

13. Birthplace Germany

MOTHER 14. Maiden Name ✓

15. Birthplace

16 (a) Informant Mr. Conrad Seeberger

(b) Address 5306 Hamlet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Brooklyn

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd.

P 25 1945 (Date received by registrar) (b) Thurlow [illegible] Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1945 at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1945 to 3/20 1945 and that I last saw h[illegible] alive on 3/23 1945

Immediate cause of death, Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Frank, Jr. M.D.

Address St. Joseph's Hosp. Date signed 3/27/45

G27184 BALTIMORE CITY HEALTH DEPARTMENT ✓ G27184
CERTIFICATE OF DEATH 13B Registered No.

Type or write in ink. Signature must be entered correctly supplied. Use correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James (Jim) Harris
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 4, 1881
8. AGE: Years 64 | Months 63 | Days 8 | 18 | If less than one day hr. min.
9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Sam Harris
13. Birthplace N. C.

MOTHER
14. Maiden Name Jennie ?
15. Birthplace N. C.

16 (a) Informant Mary Harris
(b) Address 914 Rutland Ave.
17 (a) Removal (b) Date thereof March 24 1945 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Littleton N. Carolina
18 (a) Funeral director Mrs. Robert A. Elliott's Dept
(b) Address 1097 N. Caroline St.
19 (a) (b) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1945 to 3/22 1945 and that I last saw him alive on 3/22 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions Dysphonia Ulcerated Stomach.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Neal A. Lapford M. D.
Address 522 N. Broadst Date signed 3/24/45

VS 150

G27185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

G27185 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Forrest St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giuseppe Cusimano

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Tomasina Arena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31. 1859

8. AGE: Years	Months	Days	If less than one day
85	6	23	hr. min.

9. Birthplace Italy
(Town, county, and State)
10. Usual Occupation Retired Fruit Merchant
11. Industry or business

FATHER 12. Name Anthony Cusimano
13. Birthplace Italy

MOTHER 14. Maiden Name Gracia Favalora
15. Birthplace Italy

16 (a) Informant Anthony Cusimano
(b) Address 3012 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Papitone
(b) Address 2414 E. Balto St

19 (a) 3 25 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 10 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1945 to March 23 1945, and that I last saw h— alive on 3-23 1945.

Immediate cause of death Myocardial Aneurysm — Duration 3 days
Due to Myocarditis
Due to Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard Bonfield, M.D.
Address 5401 Belair Rd Date signed 3-25-45

VS 150

G27186
CHK-47054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G27186
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 7- 22
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore-Md. 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?? Newkirk Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Markert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1874

8. AGE: Years 70 | Months 2 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Hatchman

11. Industry or business

FATHER
12. Name Francis Markert
13. Birthplace Germany

MOTHER
14. Maiden Name Victoria ??
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof March 26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2518 E. Baltimore

19 (a) 3-25-1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH March 23 1945 at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1945 to Mch. 23 1945 and that I last saw him alive on Mch. 23 1945.

	Duration
Immediate cause of death Cardiac insufficiency	?
Due to Arteriosclerotic heart Disease	?
Due to	
Other Conditions Pyelonephritis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible]
Address Balt City Hosp. Date signed 3-27-45

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G27187 - 64

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G27187

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 W. Hughes St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. Hughes St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeremiah White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Frances White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1894

8. AGE: Years 50 | Months 5/7 | Days 12 | If less than one day hr. min.

9. Birthplace Sumter, S. C.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Francis White
(b) Address 104 W Hughes St

17 (a) Removal (b) Date thereof 3/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumter
Location S. C.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 MAR 25 1945 (c) Huntington Williams, M.D.
Date received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 6 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3/17/1945 to 3/24/1945, and that I last saw h[illegible] alive on 3/23/1945.

Immediate cause of death

Chr. Vol. H. D. — 7

Due to

Due to

Other Conditions Hypotension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Layfield M. D.

Address 1522 Harlem Ave Signed 3/24/45

VS 2

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G27188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 S.CLINTON ST.
(c) Hospital or institution:

26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S.CLINTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HENRY J.PULSFORT

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: ANNA PULSFORT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): DEC.13 1866

8. AGE: Years 78 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: RETIRED

11. Industry or business:

FATHER
12. Name: JOHN T.PULSFORT
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ELIZABETH BOCKLAGE
15. Birthplace: GERMANY

16 (a) Informant: ELIZABETH PULSFORT(SISTER)
(b) Address: 917 S.CLINTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR.26/45 (month) (day) (year)
(c) Cemetery or crematory: SACRED HEART
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly & Spiler Inc.
(b) Address: 403 S.WOLFE ST.

19 (a) (Date received by registrar) Huntington Williams M.D.

MAR 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR.21 1945, at 9 am M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar.16 1945, to Mar.21 1945, and that I last saw h[illegible] alive on Mar.21 1945.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease.	
Chr.Myocarditis - L.V.Insuffic.	5-16-45
Due to Myocardial Failure	3-20-45
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: E. A. Schumunk M. D.
Address 842 S. Eastern Date signed 3-31-45

Correct age is especially important. Physicians: please write the

X

G27189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G27189
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use of information shown on this certificate for statistical purposes only is carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Since Birth

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17 -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Donald Morgenstein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 - 1925

8. AGE: Years 20 | Months — | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None -

11. Industry or business

FATHER
12. Name Louis M. Morgenstein
13. Birthplace Russia

MOTHER
14. Maiden Name Mildred Morgenstein
15. Birthplace Baltimore Md

16 (a) Informant Louis M. Morgenstein
(b) Address 2501 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-46 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location Jeffersonville Ind

18 (a) Funeral director Jeffersonville Ind
(b) Address 1439 E. Baltimore St

19 (a) Filed by registrar (b) Registrar

Burial for Williamsport, Md

3 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 1:40 p M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1946 to March 23 1946 and that I last saw h in alive on March 23 1946.

Immediate cause of death: Lobar pneumonia
Mitral insufficiency

Due to

Due to

Other Conditions Acute cardiac dilatation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadin M. D.

Address 2306 Eutaw Pl Date signed 3-24-46

627190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

627190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 21 So Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Sara Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Russia

MOTHER 14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Isaac Sass
(b) Address 21 So Calhoun St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-25-45 (month) (day) (year)

(c) Cemetery or crematory Chesh Shalom
Location

18. (a) Funeral director Jacob Evans Inc
(b) Address 4139 E Baltimore St Williams, M.R.

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23-1945, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944, to Mar. 23 1945 and that I last saw h. alive on Mar. 19 1945

Immediate cause of death General Carcinomatosis with Malnutrition

Due to Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 yr

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schatzow

Address 2028 Eutaw Pl. Date signed 3/24/45 (M. D.)

correct ago is especially important. Physicians: please write the the causes of death clearly and legibly.

VS 150

X

627191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

627191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA WALLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife David Waller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Leon Heller
13. Birthplace Austria

MOTHER 14. Maiden Name Eyel –
15. Birthplace Austria

16 (a) Informant Abel Shuller
(b) Address 2611 Eleanore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location

18 (a) Funeral director Jack Meira Inc
(b) Address 1439 E. Balto. St.

19 (a) 3-25-1945 (Date) received by registrar (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1942 to 3-23 1945, and that I last saw h.M. alive on 3-23 1945

Immediate cause of death: Coronary thrombosis
Hypertensive arteriosclerotic disease
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M.D.
Address Levindale Date signed 3/23/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

AB-92478 6-7192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a 6-7192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Holler

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-8447

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles F. Holler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25-1865

8. AGE: Years 79 | Months 3 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Housework

FATHER 12. Name George Shubbard

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Amelia Spicer

MOTHER 15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Record)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26/19 45 (month) (day) (year)

(c) Cemetery or crematory Lauder's Pk Location Balto City

18 (a) Funeral director A. Leland Evans & Son

(b) Address

MR 25 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8- 1945, to 3-23- 1945, and that I last saw h er alive on 3-23- 1945

Immediate cause of death	Duration
Cardiac failure	10 days
Due to Arteriosclerotic Cardio Vascular disease	?
Due to	
Other Conditions Fract. neck of fem.	2 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 23/2
(b) Date of occurrence 3-9-45 ? P. M
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public Home? Public place While at work? No (Specify type of place)
(e) Means of injury Fell down on floor

23. Signature Hattie L. Bolton M. D.

Address Balt. City Hosp. Date signed 3/24/45

VS 180

To be approved by the Medical Examiner Thomas J. Mullen, M.D.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Your signature is especially important.

627193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

627193
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4105 Rollins Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Rollins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon J. Leizman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7018

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sylvia A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug, 1896

8. AGE: Years	Months	Days	If less than one day
48	7		hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Tailor Dezigner

FATHER
12. Name Samuel Leizman
13. Birthplace Poland

MOTHER
14. Maiden Name Fannie ?
15. Birthplace Poland

16 (a) Informant Sylvia A. Leizman
(b) Address 4105 Rollins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124- 1126 W North Ave

MAR 29 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1945, at 2.45 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Periarteritis Nodosa

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 3/25/45

VS 151

627194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

627194
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Cold Spring Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel H. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1893

8. AGE: Years	Months	Days	If less than one day
51	5		hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia.

16 (a) Informant Mrs Bernard Caplan
(b) Address 3000 Cottage Ave

17 (a) Burial (b) Date thereof March 25, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAR 25 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943, to March 23 1945, and that I last saw h[illegible] alive on March 23 1945.

Immediate cause of death	Duration
Myocarditis Arteriosclerosis	2 years
Due to Hypertension	3 years
Due to Diabetes mellitus	1 year.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis Lobsteins M. D.
Address 1724 Eutaw Pl Date signed 3/26/45

VS 150

X.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27195 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Huntingdon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Carrie E. Pickle (Hays)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James M. Pickle

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1880

8. AGE: Years 64 | Months 3 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Hays.
13. Birthplace maryland.

MOTHER
14. Maiden Name Susan Moore
15. Birthplace Maryland.

16 (a) Informant Father B. Willis.
(b) Address 2901 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Chenoweth & Damarau
(b) Address 3615-17 Labestum Ave

19 (a) ..... (b) ..... Registrar

(Registered by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945; at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23 1945, to Mar. 23, 1945, and that I last saw her alive on Mar. 23, 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	immediate
Due to Hypertension.	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frank N. Ogburn. M. D.
Address 2701 W. Calvert St. Date signed Mar. 27 1945

X

G27196 BALTIMORE CITY HEALTH DEPARTMENT G27196
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 McHenry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry F. Rock

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wife - Carrie F.
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 5-13-83

8. AGE: Years 61 | Months 10 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Piano Salesman
11. Industry or business Jones W. Kitt Co.

FATHER
12. Name Herman (Dec.) Rock
13. Birthplace Md. Germany

MOTHER
14. Maiden Name (Dec.) Dinkelroon
15. Birthplace Md. Germany

16 (a) Informant Carrie F. Rock
(b) Address 2133 McHenry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Avenue

19 (a) MAR 25 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 19 45 to 3-24 19 45, and that I last saw him alive on 3-24 19 45

Immediate cause of death: Saddle Embolus in Aorta. — Duration

Due to: Deferred - Call March 28th 1945

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Carr Jr. M.D.
Address St. Agnes Hosp. Date signed 3/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2114 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie R. Berryman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John A. Berryman | 6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) April 3, 1852

8. AGE: Years 82 | Months 11 | Days 19 | If less than one day, hr. min. 8/62

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Labrio
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Scheaning
15. Birthplace Germany

16 (a) Informant Mrs. Geo. W. Schwabe (b) Address 2101 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1945 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George W. Schwabe
(b) Address 2101 Frederick Ave.

19 (a) APR 25 1945 (Date rec'd by registrar) (b)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942, to March 22 1945, and that I last saw h. alive on March 22 1945

Immediate cause of death Massive Cerebral Hemorrhage — Duration 1 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. McCallum M. D.

Address 3821 Fredrick Date signed 3-23-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave.
(c) Hospital or institution:
Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE A. SLAUGHTER

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John T. Slaughter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 1879

8. AGE: Years 65 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Philip B. Scherer
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Missey Mahon
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Catherine Luther
(b) Address 3936 Edmondson Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery or crematory River View
Location Richmond, Va.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 25 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1945 to 3/24 1945
and that I last saw h alive on 3/24 1945

Immediate cause of death	Duration
Pneumonia Terminal	5 days
Hypostatic	
Due to Cardio Vascular	
Lesions & De Compensation	2 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elliot W. Johnson M. D.
Address 3432 Druid Hill Ave. Date signed 3/27/45

VS 150

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

627199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 25

627199
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) UNKNOWN

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Middle River Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bonnie Darlington (Mildred DARLINGTON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas Darlington
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 27 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual Occupation: Home - wife

11. Industry or business

FATHER
12. Name ? John Jackson
13. Birthplace W Va

MOTHER
14. Maiden Name Lillie Mary Payne
15. Birthplace W Va

16 (a) Informant: Deceased
(b) Address

17 (a) Removal. (Burial, cremation, or removal) (b) Date thereof 3/25/45 (month) (day) (year)

(c) Cemetery or crematory
Location Montgomery W Va

18 (a) Funeral director Wm J Gilmer & Son
(b) Address South & Penna Avenues

19 (a) ____ (b) ____ (Date received by registrar) Registrar

25 1945
Va 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1945, to 3-24 1945, and that I last saw h. alive on 3-24 1945.

Immediate cause of death	Duration
Toxemia	
Due to Probable Peritonitis	
Due to Ruptured appendix? Congenital Septicemia?	
Other Conditions: Jaundice?	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Jamison M. D.
Address University Hospital Date signed 3-24-45

Huntington Williams, M.D.

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G27200 G27200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH ✓ 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3520 Hilton Road St.) 11 Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred.....yrs.....mos.....ds. How long in U. S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME Mary Strawbridge Mosher

If U. S. Veteran specify WAR.....

(a) Residence: No. 3409 Lyncheater Road St., ...Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. Mosher

6. DATE OF BIRTH (month, day, year) Aug 29 1853

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
91	6	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME John J. Moffitt

14. BIRTHPLACE (city or town) (State or country) Baltimore Md.

MOTHER

15. MAIDEN NAME Unknown.

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Mrs Herbert Green

(Address) 3409 Lyncheater Road

18. BURIAL, CREMATION, OR REMOVAL

Place Lorraine Cem. Date 3-27- 1945

19. UNDERTAKER Loring Byers

(Address) 3005 Park Heights Ave

20. FILED 3-27-1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 24, 1945

22. I HEREBY CERTIFY, That I attended deceased from 1- 1- 1940 to 3- 24- 1945

I last saw her alive on 3- 23- 1945. Death is said to have occurred on the date stated above, at 6 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage.	9-17-44
Arteriosclerosis	

Other contributory causes of importance:

Was an operation performed?..... Date of.....

For what disease or injury?.....

Name of operation.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) Howard A. Williams M. D.

(Address) 2604 Garrison Blvd

OCCUPATION is very important. See instructions on back of certificate.

VS 3

X

627201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627201 / 107

Registered No. .....

Type or use ink. The cause of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3301 W. ROGERS AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town 3301 W. ROGERS AVE
(If outside city or town limits, write RURAL and give town)

(d) Street No. ..... (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME DANIEL HILTZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary L. Hiltz

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 7, 1864

8. AGE: Years	Months	Days	If less than one day
81	0	17	hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business .....

FATHER — 12. Name John R. Hiltz

13. Birthplace Germany

MOTHER — 14. Maiden Name Magdilisha

15. Birthplace Germany

16 (a) Informant Mrs. Mary L. Hiltz

(b) Address 3301 W. Rogers Ave

17 (a) Burial (b) Date thereof 3-26-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location Baltimore, Md.

18 (a) Funeral director Loring Byers.

(b) Address 5005 Park Heights Ave

19 (a) MAR 25 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH. MARCH 24 1945 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 14 1945 to MARCH 24 1945; and that I last saw h/m alive on March 24 1945.

Immediate cause of death	Duration
Congestive Heart Failure	6 days
Due to Bronchio-Pneumonia	10 days
Due to	
Other Conditions Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature Sherman R Hantz M. D.

Address 2401 Manhattan Ave Date signed 3/24/45

X

G27202 — BALTIMORE CITY HEALTH DEPARTMENT — G27202 Registered No.

CERTIFICATE OF DEATH

53 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Bialek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed.

6 (b) Name of husband or wife Joseph Bialek (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73	4mo		hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Francis Lerdowich.

13. Birthplace Poland

MOTHER 14. Maiden Name Antoinette Jabcaczu

15. Birthplace Poland

16 (a) Informant Hospital Records

(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary (cem

Location Baltimore County

18 (a) Funeral director John M. Welsh

(b) Address 409 S. Chester Street

19 (a) MAR 26 1945 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1945, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1945 to 3/21 1945, and that I last saw h.e.r alive on 3/21 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Generalized Abdominal Carcinoma & Metastasis.	?
Due to Degenerative C-V. Disease	prev
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl N. Patterson M. D.

Address Mercy Hosp. Date signed 3/21/45

Vs 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

627203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 48A

627203
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 W. Henrietta St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State West Virginia County Randolph
(c) City or town Millcreek
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 Box 31
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hope M. Swiger

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Homer Swiger
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 20, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	4	hr. min.

9. Birthplace Randolph Ct. West Virginia
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Thomas J. Armstrong
13. Birthplace Randolph Ct. W. Virginia

MOTHER
14. Maiden Name Barthenia Chandler
15. Birthplace Randolph Ct. W. Virginia

16 (a) Informant Mrs. Homer Swiger
(b) Address 8 W. Henrietta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26/45 (month) (day) (year)
(c) Cemetery or crematory Elkins
Location West Virginia

18 (a) Funeral director Fred A. Frances Sons
(b) Address 216 N. Charles St.

MAR 26 1945
(b) Date rec'd by registrar
Registrar

Huntington-Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/45 19 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 46 to 3/24 19 45.
and that I last saw h e alive on 3/24 19 45.

Immediate cause of death Carcinoma of Cervix

Duration
3 mos

Due to

Due to

Other Conditions Generalized metastases
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D.
M. D.
Address 122 E. D. Charles St. Date signed X 3/25/45

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important. Do not use abbreviations or symbols. Entries must be typewritten or legibly printed.

G27204
JL - 91085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/3B

Registered No. G27204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 11 V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Neenan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of ~~husband or~~ wife Marie E. Neenan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13, 1902

8. AGE: Years	Months	Days	If less than one day
42	11	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Ship Yard Worker
11. Industry or business Bethl. Sparrows Pt. Co

FATHER
12. Name James
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Slattery
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Cross
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 26 1945 (Date rec'd by registrar) (b) Eustace F. Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1945 19 , at 9.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1944, to March 22 1945, and that I last saw h im alive on March 22 1945.

Immediate cause of death	Duration
Empyema	1 mt.
Due to Pulmonary Tuberculosis bilateral	4 yrs.
Due to	
Other Conditions Pericarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Dillon M. D.
Address Bd to City Hosp. Date signed 3/23/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. 627205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Mt. Royal ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Minnie Stuart.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13th 1876

8. AGE: Years 68 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Richard H. Stuart
13. Birthplace Va

MOTHER
14. Maiden Name Sarah E. Meade
15. Birthplace Millersville Md.

16 (a) Informant J. E. Collins
(b) Address 3406 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery or Crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1945; at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1945 to 3/24 1945 and that I last saw h.e. alive on 3/23 1945

	Duration
Immediate cause of death: Cardiac failure	
Due to	
Due to	
Other Conditions: Strangulated hernia - gangrenous bowel (Include pregnancy within 3 months of death)	

Date of operation 3/23/45

Major findings of operation: Strangulated hernia - gangrenous bowel

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Sites M. D.
Address St Agnes Hosp Date signed 3-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627206 ✓ 627206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 E Preston St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George J. Recklein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband~~ wife Lottie Recklein
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 14th 1876

8. AGE: Years	Months	Days	If less than one day
68	3	7	.....hr. .....min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business B & O R.R.

FATHER
12. Name Unknown Recklein
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Evelyn Recklein
(b) Address 932 E. Preston St

17 (a) Burial (b) Date thereof 3/26/45 (month) (day) (year)
(Burial, ~~cremation~~, or removal)
(c) Cemetery ~~or crematory~~ Balto
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) MAR 26 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 19 45, at 0429 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry ~~Inspection~~ and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ ~~accident~~ ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature C. J. Lubrinski M.D.
Medical Examiner.
Date signed 3/27/45

627207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 627207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Agnes E. Hambleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband Henry S. Hambleton 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27th 1870

8. AGE: Years 74 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business None

FATHER
12. Name Steven Hastey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Garvey
15. Birthplace Ireland

16 (a) Informant Emily N. Doyle
(b) Address 1006 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) Mar 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1945, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1945, to 3/23 1945, and that I last saw her alive on 3/23 1945.

	Duration
Immediate cause of death Cerebral Vascular Accident	4 da.
Due to Hypertens. C-V Dis.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Paul Tompkins M. D.
Address Mercy Hosp. Date signed 3/26/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

627208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a Registered No. 627208

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 75 S. Wolfe St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Ferdinand H. Sturm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1868

8. AGE: Years 76 Months Days 26 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Hubert Sturm
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hanschar
15. Birthplace Germany

16 (a) Informant Rev. Harry Missig
(b) Address 7 S. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 26 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Undertaker Wm. H. Diggs Sons
(b) Address 37 S. Ann St.

19 (a) MAR 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1945, at 4:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1945, to 3/22 1945, and that I last saw h. alive on 3/21 1945.

Immediate cause of death Cardiac Failure — Duration

Due to Heart block

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Sturm

Address St. Joseph's Hosp. Date signed 3/23/45 M.D.

G27209

BALTIMORE CITY HEALTH DEPARTMENT 160 C Registered No. G27209

CERTIFICATE OF DEATH

Please write plainly with pen or indelible pencil. Physicians are requested to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Patterson Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Beaufort Ave. 15
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kleoze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			20 hr. 20 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Nathan Kleoze
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Anna Gudis
15. Birthplace Russia

16 (a) Informant Anna Kleoze
(b) Address 5304 Beaufort Ave (15)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 24 1945

18 (a) Funeral director Commissioner of Health
(Address) MAR 25 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 8:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1945 to 3/16 1945.
and that I last saw him alive on 3/16 1945.

Immediate cause of death	Duration
Congenital Atelectasis	
Due to Prematurity (2-6 weeks)	
Due to Separation of normal embedded placenta	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Goldmann
Address 2326 Cedar Rd Date signed 3/17/45

VS 3

599

G27210 ✓ G27210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83R

Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Paynis + Dulaland Ave.

(c) Hospital or institution: West Balt. Gen. Hosp 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.

(e) Length of stay in Baltimore (yrs., mos., or days) 23yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 316 W. Saratoga St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** ~~Mrs~~ Ida B. MORRISON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John E. Morrison | 6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 11/8/1898

8. AGE: Years 46 | Months 4 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace Indiana Evansville (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER 12. Name John Dorrington

13. Birthplace Evansville Indiana

MOTHER 14. Maiden Name

15. Birthplace Virginia

16 (a) Informant John E. Morrison

(b) Address 316 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Baltimore, Md.

18 (a) Funeral directors J. B. Hepburt Son

(b) Address 1300 Eutaw Place

19 (a) MAR 26 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1945 at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1945 to 3/22 1945, and that I last saw h. alive on 3/22 1945

Immediate cause of death Cerebral and sub-arachnoid hemorrhage — Duration

Due to Hypertension - (Essential?)

Due to

Other Conditions Retinal and conjunctival hemorrhage.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. M. Lehenfeld M. D.

Address West Balt. G. H. Date signed 3/22/45

VS 180

Huntington Williams, M.D.

X

7211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. 627211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2529 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 2529 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elene Hope Zlotowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-13-45

8. AGE: Years | Months | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris D. Zlotowitz
13. Birthplace Poland

MOTHER
14. Maiden Name Fannie B.
15. Birthplace Phila Pa

16 (a) Informant Morris D Zlotowitz
(b) Address 2529 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Sagel Lewis Inc
(b) Address 1439 E. Balto St

19 MAR 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1945, to March 25 1945, and that I last saw her alive on 3/25 1945.

Immediate cause of death: Status Lymphaticus

Due to

Due to

Other Conditions Acute Intestinal Disorder

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Meyer Miller M. D.
Address 4432 Park Heights Ave Date signed 3/26/45

64

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Spec—12-23-21—E.B.R.S.—400 Blks.

627212

HEALTH DEPARTMENT—CITY OF BALTIMORE

627212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 631 S. ~~Fraction~~ Hudson St. W. Ward) Registered No. 1116

2-FULL NAME Wm. Fredrick Schnitzger (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 6318 Hudson St. Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or ~~Divorced~~, (Write the word.): W.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline Hinz

6-DATE OF BIRTH (month, day and year): June 16-1859

7-AGE: 86 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs. Frank A. Pfaff
(Address): 6318 Hudson St

15- Filed MAR 26 1945 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3/22/45

17- I HEREBY CERTIFY, That I attended deceased from 1940, 19..., to March 22 45, 19...
that I last saw h/ alive on 3/15 1945
and that death occurred, on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:
Coma Cardiac

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Dislocated r. Shoulder
Terminal Pneumonia (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?
Shoulder replaced 2/14/45
Did an operation precede death? Date of 1940
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Dr. [illegible] M. D.
3/23/45 (Address) 4613 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 3/26 19 45
Lemwerth	
20-UNDERTAKER, Clarence F. Hoffman	ADDRESS 1639 Bro[illegible]

G27213 — BALTIMORE CITY HEALTH DEPARTMENT — 93 D — G27613 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Mt. Olivet Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OSCAR H. WERNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	216-05-8558

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth C. Werner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	13	hr. min.

9. Birthplace New York City, N. Y. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business --

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Elizabeth Werner
(b) Address 312 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 26 1945 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1945, at 7:55P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to March 22 1945, and that I last saw h~~is~~ alive on March 19 1945.

Immediate cause of death: Cerebral Hemorrhage + paralysis — Duration: 3 days
Due to: advanced arteriosclerosis — P
Due to:
Other Conditions: hypertension — chronic
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Walter L. Dublin M. D.
Address 22 E. Harrison Pl. Date signed March 24/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Chatham Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Raehrle

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1864

8. AGE: Years	Months	Days	If less than one day
81	0	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business Real Estate

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Lydia M.J. Boteler
(b) Address 5408 Gwyndale Ave. Baltb. 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons.
(b) Address North & Pennsylvania Aves

19 (a) (Date rec'd by registrar) MAR 26 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1945 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured ribs; burns about

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/19/45 at 9 A. M.
(b) Where did injury occur? Liberty Hgts & Garrison Blvd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Meeder M.D. Medical Examiner.
Date signed 3-29-45

VS 151

G27215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G27215 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Jackson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Jackson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Tully

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24. 1945

8. AGE: Years | Months | Days | If less than one day 7 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Irving Tully
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Grace V. Schmidt
15. Birthplace Balto Md

16 (a) Informant Irving Tully
(b) Address 1808 Jackson St.

17 (a) Burial (b) Date thereof 3-26-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross - Wanford Rd
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3197 W. North Ave

19 (a) MAR 26 1945 (b) Thurlington W. Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION 10.30

20. DATE OF DEATH Mar. 24. 1945, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1945 to 19, and that I last saw h[illegible] alive on March 24 19 45.

Immediate cause of death Morbus Cerebralis — Morbus caeruleus — Duration 3 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O B Mellott M. D.
Address 1279 Mulberry Date signed 3/26 1945

627216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓ 627216 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 E.28th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 E.28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Charles H.Neutze

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 714-03-4036

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louisa K.Neutze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr.6,1887

8. AGE: Years 57 | Months 11 | Days 7 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business R.R.Exp.Co.

FATHER
12. Name Henry Neutze
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Wagenführer
15. Birthplace Germany

16 (a) Informant Louisa K.Neutze
(b) Address 1510 E.28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.27/45 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem.
Location Balto., Md.

18 (a) Funeral director Philip Harry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) MAR 26 1945 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23/45 19 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to 3/23/45, and that I last saw him alive on Mch 20 1945.

Immediate cause of death: Hy pertension
Cerebro Vas cular Disease — Duration 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip J. Thimgen M. D.
Address Harford & Bk Date signed March 24 1945

G27217 ✕✓ G27217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Laverne ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton LeVerne Nevins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1929

8. AGE: Years	Months	Days	If less than one day
15	7	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name William B. Nevins
13. Birthplace Penna.

MOTHER
14. Maiden Name Emma E. Burg
15. Birthplace Balto. Md

16 (a) Informant William B Nevins
(b) Address 121 Laverne ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) MAR 26 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945; at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1945, to Mar 22 1945, and that I last saw him alive on Mar 22 1945.

Immediate cause of death	Duration
Second & third degree burns of lower extremities & lower portion	
Due to Of trunk, forearm & thumb	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence March 10 1945 at 9:25 A M
(c) Where did injury occur? Curtis Bay (City or town) / (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? Yes
(e) Means of injury Explosion following gasoline on wood

23. Signature Paul E Lukats M. D.
Address 1213 Light St. Date signed 3-23-45

For B John R. Davis, by Howard J. Woodcock, M.D.

627218 ✓ 627218

AB-92230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos- 2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Latrobe Park Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles Worthington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma (D) nee Applegarth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5-1867

8. AGE: Years 77 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business E. Mills & Sons

FATHER
12. Name Price Worthington
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Reeder
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Fairmount Ave

18 (a) Funeral director Harry H Witzke
(b) Address 401 Edmondson Ave

19 (a) MAR 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23- 1945, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1945 to 3-23- 1945, and that I last saw him alive on 3-23- 1945

	Duration
Immediate cause of death: Cachexia	?
Due to: Carcinoma of hard palate	?
Due to: Carcinoma of head of pancreas	?
Other Conditions: fracture neck of right femur (Include pregnancy within 3 months of death)	1 month

Date of operation 3-10-45

Major findings of operation: Carcinoma of head of pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-21-45 at ? P M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell down

23. Signature Hallek E. Bolton M. D.
Address Baltimore City Hosp Date signed 3/24/45.

To be approved by the Medical Examiner
For H. B. McNally by Howard J. Tilden M.D.

G27219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27219 Registered No.

JO #92601

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1356 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Cassidy or Ida Caster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
66?	?	?	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unable to obtain information.

11. Industry or business

FATHER
12. Name John Diggs
13. Birthplace Va.

MOTHER
14. Maiden Name ? ?
15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 (a) MAR 26 1945 Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1945, at 7:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16, 1945, to Mar. 21, 1945, and that I last saw her alive on Mar. 21, 1945

Immediate cause of death	Duration
Cardiac	2
Due to arteriosclerotic heart disease	?
Due to	
Other Conditions Cerebral arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. Whalley M.D.
Address Baltimore Md. Date signed 3-24-45

G27420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G27420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 S. MACON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. MACON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE PARSONS

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY A. PARSONS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 4 1893

8. AGE: Years	Months	Days	If less than one day
52	0	20	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation ELETRIC WELDER
11. Industry or business SP. POINT SHIP CO.

FATHER
12. Name HARRY PARSONS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name HENERIETTA CALLENDER
15. Birthplace BALTO. MD.

16 (a) Informant MARY A. PARSONS (WIFE)
(b) Address 310 S. MACON ST.

17 (a) BURIAL (b) Date thereof MAR. 28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (b) Huntington Williams, M.D.

MAR 26 1945

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH MAR. 24 1945 at 8/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22- 1945 to 3-24 1945 and that I last saw h— alive on 3-24 1945

Immediate cause of death Coronary Thrombosis — Duration 15 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Daniels M. D.
Address 3218 Eastern ave Date signed 3-26-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

7221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63A

G 27221 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Md.
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Negro
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Grace Johnson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 8, 1904
8. AGE: Years 41 Months -1 Days -15 If less than one day — hr. — min.
9. Birthplace Kenbridge, Va. (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business —
FATHER 12. Name Wm Johnson
13. Birthplace Kenbridge Va
MOTHER 14. Maiden Name Sally Blackwell
15. Birthplace Kenbridge, Va
16 (a) Informant Mrs. Grace M. Johnson
(b) Address 1901 McCulloh St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk. Location Baltimore Co. Md.
18 (a) Funeral director Mrs. Geo. H. Hall
(b) Address 1631 Druid Hill Ave
MAR 26 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 1945, at 12 50 M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1945 to Mar. 23 1945, and that I last saw h[illegible] alive on Mar. 23 1945.

Immediate cause of death: Post-operative psychosis & exhaustion — Duration
Due to Post-operative psychosis & exhaustion.
Due to
Other Conditions Massive colloid goitre (thyroid adenoma)
(Include pregnancy within 3 months of death)
Date of operation 3/15/45
Major findings of operation: Massive thyroid adenoma
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James S. Rigas M. D.
Address 1514 Division Date signed 3/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 197

Registered No. G27222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1574 Division
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore ~~(yrs., mos., or days)~~ 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Mc Mechen
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Polston

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business —

FATHER
12. Name John Polston
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary Jane Stewart
15. Birthplace Harford Co. Md.

16 (a) Informant Benjamin Polston
(b) Address 529 Mc Mechen St.

17 (a) Burial (b) Date thereof March 27, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Jno. Chas. S. Stallings
(b) Address 1651 Druid Hill Ave.

MAR 26 1945
(Date rec'd by registrar) (Registrar for Williams) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24th 1945, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1945 to March 24 1945, and that I last saw him alive on 24th March 1945.

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to Arteriosclerosis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. H. Bamford M.D.
Address Provident Hospital Date signed 3/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27223 G27223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Schwind

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Schwind
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Giles
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Mar 27. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b)
(Date received by registrar) (Registrar)
MAR 26 1945

VS 150

correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch - 24 1945, at 11-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-10 1945, to Mch 24 1945, and that I last saw her alive on Mch 24 1945

	Duration
Immediate cause of death: Edema of Lungs	2 days
Due to: Chronic Myocarditis	3 yrs
Due to:	
Other Conditions: Arteno-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 3/26/45

X

G27224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27224 Registered No. 164C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Trailer Camp - Georgetown Rd and Caton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Trailer Camp: Georgetown Rd & Caton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Schecker Scheckler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1889

8. AGE: Years	Months	Days	If less than one day
55	9	22	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Steam Engineer
11. Industry or business Nav Govt

FATHER
12. Name Wm L Scheckler
13. Birthplace Penna

MOTHER
14. Maiden Name Lucinda Moyer
15. Birthplace Penna

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26th 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Pattersville Pa.

18 (a) Funeral director Leo G. Leook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) MAR 26 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 22 - 1945 at 3 30 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shot gun wound of chest, involving Heart & lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-22- at P. M.
(b) Where did injury occur? Trailer Camp Georgetown Rd and Caton ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm (Shotgun)

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 3-23-45

627225 627225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Week
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4145 Eierman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME xxxxxxxxxxxxxxxxxx MYRTLE MAY BOYD

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward W. Boyd, Sr.
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 18, 1900
8. AGE: Years: 44 Months: 10 Days: 5 If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Thomas H. Gaskins
13. Birthplace: Newbern N.C.

MOTHER
14. Maiden Name: Ellen Wheeley
15. Birthplace: Baltimore, Md.

16 (a) Informant: Edward W. Boyd, Sr.
(b) Address: 4145 Eierman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-26-45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Filed: MAR 26 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945 at 9 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1945 to 3-24 1945 and that I last saw her alive on 3-24 1945

Immediate cause of death: generalized peritonitis — Duration: 6.
Due to: Perforation from malignancy of sigmoid
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 3-19-45
Major findings of operation: Peritonitis + Cancer of sigmoid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Carl Myers M. D.
Address: Franklin Square Hosp.
Date signed 3-24-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

627220 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as correct age is especially important. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County - - -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Crossland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY PAULY

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-07-3130

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Magdalene Bauereis

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 26. 1884

8. AGE: Years 60 | Months 3 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Teller-Bank

11. Industry or business Equitable Trust Co.

FATHER
12. Name Henry Pauly
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Gehb
15. Birthplace Baltimore

16 (a) Informant Mrs. Magdalene B. Pauly
(b) Address 3403 Crossland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27. 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore County

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (a) MAR 26 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24. 1945 at 8.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1944 to 3/24 1945, and that I last saw h[illegible] alive on 3/21 1945

Immediate cause of death: Rheumatic Heart Disease — Duration: 5 years?
Mitral Stenosis
Due to: Cardiac Decompensation
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Sol Smith
Address 1223 E. Mark Date signed M. 3/25/45 D.
Balto - 2, Md

VS 180

G27227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G27227
Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Dulaaland
(c) Hospital or institution: West Balt. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2869 Garrison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HARRY TH BUCHMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mamie F Belt
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec 2-1870

8. AGE: Years 74 | Months 3 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Michael Buchman
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Frank
15. Birthplace Md

16 (a) Informant Mrs Harry T. Buchman
(b) Address 2869 Garrison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26/45 (month) (day) (year)
(c) Cemetery or crematory Grace
Location Balto co.

18 (a) Funeral director Edw Tipton
(b) Address Hampstead, Md

19 (a) Date received by local registrar MAR 26 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 19 45 at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 19 45 to 3/25 19 45 and that I last saw him alive on 3/25 19 45.

Immediate cause of death Chronic Lobar Pulmonary Tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Silverfield M. D.
Address West Balt Gen Hosp Date signed 3/25/45
A Silverfield

VS 150

G27228 G27220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 838 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Bayard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Bayard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Grill

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 212-18-7409

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1881

8. AGE: Years 64 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business City Hospitals

FATHER
12. Name William Grill
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schuman
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Grimes
(b) Address 1003 Bayard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28. 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) MAR 26 1945 (Date rec'd by registrar) (b) Hunter Scott Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 18 1945 to Mch 25 19; and that I last saw h alive on Mch 25 19

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	3 Months
Due to Arteriosclerosis	— —
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert Dean, M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G27229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G27229 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3566 Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3566 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys R. Catterton

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Z. Catterton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1898

8. AGE: Years	Months	Days	If less than one day
47	–	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Catterton
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Hood
15. Birthplace Maryland

16 (a) Informant Mrs. Helen Evans
(b) Address 3909 Fairhaven Av (26)

17 (a) Burial (b) Date thereof 3/27/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cem.
Location Glenburnie Md.

18 (a) Funeral director Milton Schilling (25)
(b) Address 3914 Hanover Av (25)

19 MAR 26 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945, at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, spontaneous

Due to Ruptured aneurysm of circle of Willis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gratiaa M.D.
Medical Examiner.
Date signed March 24, 1945.

G27230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1372

G27230 Registered No.

Physicians: please write the causes of death clearly and legibly. Information as to age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 E. Fairmount ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E. Fairmount ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Shreck.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife January 10, 1880

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bricklayer

11. Industry or business

FATHER
12. Name Wm. Shreck
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia Wyatt
15. Birthplace Baltimore Md.

16 (a) Informant Lillian Shreck.
(b) Address 1911 E. Fairmount ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Howard H. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

MAR 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1945 to March 24 1945 and that I last saw he alive on March 24 1945

Immediate cause of death
Uremia — Duration 3 days

Due to Prostatic Hypertrophy — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Snidler

Address 1610 E. Fayette St Date signed 3/26/45

X

G27231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G27231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. Benjamin T. Godwin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of ~~husband or~~ wife Kate A. Godwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30th 1859

8. AGE: Years 85 | Months 7 | Days 25 | If less than one day — hr. — min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name (Unknown) Godwin
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jeffreys
15. Birthplace Md.

16 (a) Informant B. Harry Godwin
(b) Address 504 Virginia Av Towson Md.

17 (a) Burial (b) Date thereof 3/28/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ M. E. Church
Location Abingdon Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date received by registrar) MAR 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13- 1945 to 3-25-1945 and that I last saw h. alive on 3-25-1945

Immediate cause of death Ac. Congestive Failure
Due to Arterio Sclerosis
Due to Cerebral Hemorrhage
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Houston L. Bell M. D.
Address Mercy Hosp. Date signed 3-26-45

Physicians: please write the causes of death clearly and legibly. Be sure that information shown is correctly supplied. The correct age is especially important.

Funeral Home, Huntington Turnpike, Md.

G27232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 N. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Riley

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 19th 1883

8. AGE: Years: 61 | Months: 11 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Pa
(Town, county, and state)

10. Usual Occupation: Retired Fireman
11. Industry or business: City of Balto

FATHER
12. Name: William Riley
13. Birthplace: Pa

MOTHER
14. Maiden Name: Annie Dietrich
15. Birthplace: Pa

16 (a) Informant: Alma Waskey
(b) Address: 1311 Poplar Grove St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director: William Cook Inc
(b) Address: Park & Lafayette

MAR 26 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/1945, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-vascular Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Enright B. McNally M.D.
Medical Examiner.

Date signed 3/24/45

627233 (2) BALTIMORE CITY HEALTH DEPARTMENT 627233

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gaysour + Fayette Sts
(c) Hospital or institution:
Bon Secour Hosp't. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Yale Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Sarah E. Cunabaugh.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Wm. E. Cunabaugh

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1885

8. AGE: Years 59 | Months 5 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name John. T. Peacock
13. Birthplace Md.

MOTHER
14. Maiden Name Mary. Barnes.
15. Birthplace Md

16 (a) Informant Mr Joseph V. Cunabaugh
(b) Address 429 Yale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4209 Old Frederick Road.

18 (a) Funeral director John Cowan & Son
(b) Address 901 03 Hollins Sts.

19 (a) ____ (b) Registrar Huntington Williams M.D.
(Date received by Registrar)

MAR 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1945 at 12 m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1945 to 3-24 1945 and that I last saw h.. alive on 3-23 1945

Immediate cause of death: Cerebral Embolism — Duration: 1 month

Due to: C-V. Hypertension — 1 year

Due to: —

Other Conditions: Hemiplegia Rt Side
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 3-29-45

X.

627234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

627234 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rosedale (If outside city or town limits, write RURAL and give town)
(d) Street No. 7916 Bridge ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis. Slomba Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1930

8. AGE: Years 14 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Slomba Sr.
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Frances Bubczyk
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Frances Slomba
(b) Address 7916 Bridge ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rozary
Location Baltimore Co. Md.

18 (a) Funeral director George A. Weber
(b) Address 705 - S. Linn street

19 (a) (Date received by registrar) MAR 26 1945 (b) Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1945 at 8 46 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1945 to 3/25 1945 and that I last saw him alive on 3/25 1945

Immediate cause of death Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmer Hoffman M. D.
Address Sinai Hospital Date signed 3/25/45

G27235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. G27235 (na)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 W Fayette St
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1619 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Roland LEISHER

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-7026

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1917

8. AGE: Years 28 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Laurel Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name William [illegible] Leisher
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Sandoson
15. Birthplace Laurel Md.

16 (a) Informant Mary Leisher
(b) Address 1619 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27-45 (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel Md.

18 (a) Funeral director Bernard A Fink
(b) Address 3613 Belair Rd.

MAR 26 1945 (Date rec'd by Registrar) (b) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to March 24 1945.
and that I last saw h.m alive on March 23 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roland Campbell
Address Box Campbell Date signed 3/27/45

FORMS WHITE & CRIGHT, INC., BALTIMORE, MD.
Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

Registered No. 627236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mothers home 869 Paca St (If rural, give location) Balto
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-21-45

8. AGE: Years	Months	Days	If less than one day
		1 day	hr. min.

9. Birthplace Univ Hosp (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name Mother Mary Gross
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (Date rec'd by registrar) (b) Huntington, Williamsport, Md.

UNIVERSITY MEDICAL SCHOOL MAR 26 1945

MAR 26 1945 Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1945, at 4 20/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1945 to 3-22 1945, and that I last saw him alive on 3-22 1945

Immediate cause of death	Duration
Prematurity	
Due to: ? Atelectasis	
Due to: ? Intracranial Hemorrhage.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Faulkner M. D.
Address Univ Hosp Date signed 3-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

2603

67237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered [illegible]

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Balto.~~ Texas
(If outside city or town limits, write RURAL and give town)
(d) Street No. Brook Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Bagley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/45

8. AGE: Years	Months	Days	If less than one day
		2 3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wm. Paul Bagley
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Hughes
15. Birthplace W. Va.

16 (a) Informant Father
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery [redacted] MAR 26 1945
Location [redacted]

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 26 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1945, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1945 to 3/19 1945 and that I last saw h[illegible] alive on 3/19 1945

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Robert Mackenzie M.D.
M. D.
Address Univ. Hosp. Date signed 3/19/45

VS 150

2602

G27238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓107

G27238 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3242 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3242 Foster Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph W. Warga ✓

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 217-03-6869

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m/c	white	divorced

6 (b) Name of husband or wife Nov. 6, 1905
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
39	4	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Car - Loader
11. Industry or business

FATHER
12. Name Joseph F. Warga
13. Birthplace Austria-Hungary

MOTHER
14. Maiden Name Katherine Krystine
15. Birthplace Poland

16 (a) Informant Katherine Warga
(b) Address 3242 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Stephen J. Falkowski
(b) Address 1000 S. Kenwood Ave.

19 (a) MAR 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1945, to 3-24 1945, and that I last saw h~~im~~ alive on 3-24 1945.

Immediate cause of death	Duration
Bronchial Pneumonia	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. Davidow M. D.
Address 3218 Eastern Ave. Date signed 3-24-45

VS 150

X

627239 627239

JO #92664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 528

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Any supplementary information

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1855

8. AGE: Years	Months	Days	If less than one day
89	7	16 6	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unable to obtain information

11. Industry or business

FATHER
12. Name Daniel
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Thompson
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) L (Burial, cremation, or removal) (b) Date thereof 3-27-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Leo Preston Limbert
(b) Address 579 Mosher St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 28 1945 Huntington Hillcrest, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945 at 5:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20, 1945, to Mar. 23, 1945 and that I last saw him alive on Mar. 22, 1945.

Immediate cause of death	Duration
Cardiac failure	?
Due to Arterio-sclerotic heart disease	?
Due to	
Other Conditions Carcinoma of bladder	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of urinary bladder

PHYSICIAN
Underline the cause to which death should be charged, statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Houck E. Belton M.D.
Address Balt. City Hosp Date signed 3/25/45

93D

G27240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27240
Registered No.

Please answer questions 1 to 23 by information shown in capitals. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 E. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Abonnel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2nd 1876

8. AGE: Years 69 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles
13. Birthplace Md

MOTHER
14. Maiden Name Annie Frazier
15. Birthplace Md

16 (a) Informant Mrs Mary Wood
(b) Address 2403 E Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29th 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Leo G. Cook
(b) Address 1901-03 N. Patterson Park Ave.

19 (a) (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MAR 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24th 1945, at 2 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h.er alive on 3/23 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 1 week

Due to Hypertensive Arterio Sclerotic Cardio Vascular Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss M. D.
Address 1927 E North Ave. Date signed 3/26/45

X

G27241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

482

Registered No. G27241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W.Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 E. Lanvalle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Mantegna

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~xxxxx~~ Mariano Mantegna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18 1884

8. AGE: Years	Months	Days	If less than one day
61	1	6	hr. min.

9. Birthplace Calascibetta Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Carmelo Fulco
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Gilberto
15. Birthplace Italy

16 (a) Informant Mariano Mantegna (Husband)
(b) Address 1625 E.Lanvalle St.

17 (a) Burial (b) Date thereof March 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vace
(b) Address 52 N.Morley St.

MAR 27 1945 (b) Huntington Williamsport Md
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1945 at 2.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1945 to 3-24 1945, and that I last saw her alive on 3-23 1945.

Immediate cause of death	Duration
Congestive Heart Failure	?
Due to Generalized Carcinomatosis	3 Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C Hayden M. D.
Address Bon Secours Date signed 3-26-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

607242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3/2

Registered No. 607242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 Shannon Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth K. Hewitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband or wife Stephen D. Hewitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9th 1867

8. AGE: Years 78 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name John Bixby
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Jacobs
15. Birthplace Germany

16 (a) Informant Earl D. Hewitt
(b) Address 3623 Shannon Drive

17 (a) Burial (b) Date thereof 3/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St.

19 (a) (Signature of registrar) Huntington Williamson M.D.
(b) Date received MAR 27 1945

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24th 1945, at 5-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1943, to Mar 24 1945, and that I last saw h[illegible] alive on Mar 24 1945

Immediate cause of death: Myocardial Failure — Duration 2 days

Due to Pneumonia (Hypostatic) — 2 days

Due to Chronic Cardio Vascular Renal disease — years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George J. Bayley M.D.

Address Bayley & Bolton Date signed Mar 26 45

X Bayley

G27243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G27243
Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write, with unfailing ink, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2839 Huntington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Veronica Ann Frantzen

3 (b) If veteran, name war — 3 Army Serial Account No. 12081651

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1945

8. AGE: Years	Months	Days	If less than one day
	1	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clyde Joseph Frantzen
13. Birthplace [redacted] New York

MOTHER
14. Maiden Name Rebecca Francis McCafferty
15. Birthplace Maryland

16 (a) Informant Mrs Rebecca Frantzen
(b) Address 2838 Huntington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1219 St. Paul St

19 MAR 27 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1945 to March 24 1945, and that I last saw her alive on March 21 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Bronchopneumonia	one wk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy B. Turner, Jr. M. D.
Address Mercy Hospital Date signed 3/24/45

VS 150

G27244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

G27244 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamsnett ave
(c) Hospital or institution: Pine Ridge Conval. Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 E. Madison St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Maroucek

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank Maroucek
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 26, 1868
8. AGE: Years 76 | Months 10 | Days 24 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Conrad
13. Birthplace Austria

MOTHER
14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Frank Maroucek
(b) Address 2308 E. Madison St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Frank Woodson
(b) Address 900 E. Chester St
19 MAR 27 1945 (b) Registrar Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1945, at 3 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1945 to March 24 1945 and that I last saw her alive on March 11 1945
Immediate cause of death: Cerebral Hemorrhage (apoplexy) — Duration 12 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph Pokorny
Address 2200 E Madison St Date signed 3/24/45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Eresham Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Eresham
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward H. Rosseter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary (Jones)
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec 21, 1876

8. AGE: Years 68 | Months 3 | Days 3 | If less than one day: hr. min.

9. Birthplace Pekin, Illinois
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business None

FATHER
12. Name Edward H. Rosseter
13. Birthplace Oswego, N.Y.

MOTHER
14. Maiden Name Helen Geary
15. Birthplace Lockport, New York

16 (a) Informant Mrs Mary Rosseter
(b) Address 804 Eresham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave at Rose St.

18 (a) Funeral director John F Henry Inc
(b) Address 715 Light St.

19 (a) Date received (b) Huntington Williams, M.D. Registrar

MAR 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/45 19, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Mar 24 1945 and that I last saw h.r. alive on Mar 1 1945

Immediate cause of death: Coronary Occlusion — Duration 1 hr

Due to:

Due to:

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Lazenby

Address 721 Medical Arts Bldg Date signed 3/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. A. L. Wilkinson
5713 Belair Road

G27246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 152 G27246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5215 Anthony Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Anthony Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Nuth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John A. Nuth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1877

8. AGE: Years	Months	Days	If less than one day
67	5	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Friskey
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Milchling
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Nuth
(b) Address 5215 Anthony Avenue

17 (a) Burial (b) Date thereof 3/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MAR 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6 1945, to Mar 25 1945, and that I last saw h.. alive on Mar. 24 1945.

Immediate cause of death	Duration
Cerebral hemmorrhage	3 days
Due to	
Arteriosclerosis	Many yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M.D M. D.
Address 5713 Bel Air Rd. Date signed 3-26-45

X

vs

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

Registered No. G27247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Homestead St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 718 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhom E Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Elizabeth Ann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1879

8. AGE: Years 65 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Wm. Schmidt Co

FATHER
12. Name Leonides J Dodson
13. Birthplace Md

MOTHER
14. Maiden Name Ida Lenhart
15. Birthplace Baltimore Md

16 (a) Informant Lenny E Jefferson
(b) Address 718 Homestead St

17 (a) Burial (b) Date thereof 3/29/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loraine Md
Location Mt Olive Md

18 (a) Funeral director Wilhom Col Jr
(b) Address 1217 Eutaw St

19 (a) (b) Date received by local registrar (Signature of local registrar)

MAR 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 3/25 1945 and that I last saw h was alive on March 25 1945

Immediate cause of death Ch. Myocarditis — Duration 2 yrs.

Due to Rheumatism — 7 years

Due to Inf. arthritis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature JS Harding M.D.
Address 4810 Bel Rd Date signed 3/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G27243

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel 6
(c) City or town Linthicum Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Mae Yeatman

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widow

6 (b) Name of husband or wife George W. Yeatman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/ 1874

8. AGE: Years	Months	Days	If less than one day
70	4	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas C. Pancoast
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown Howeth
15. Birthplace "

16 (a) Informant Miriam F. Carr
(b) Address 414 Cleveland, Linthicum

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 10.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18, 1945 to March 25 1945 and that I last saw h 61 alive on March 25, 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 week
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney L. Lan M. D.
Address 2372 Eastern Pkwy Date signed 3/28/45

VS 3

G27249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G27249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Robert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1896

8. AGE: Years 48 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Lancaster Co., Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Moses Fisher
13. Birthplace Va.

MOTHER
14. Maiden Name Louise Montague
15. Birthplace Va.

16 (a) Informant Mrs Obélia Smith
(b) Address 530 Robert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-27-45 (month) (day) (year)
(c) Cemetery or crematory
Location Kilmarnock, Va.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) MAR 27 1945 Registered by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1945, at 7.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1945 to 3/23 1945, and that I last saw h[illegible] alive on 3/23 1945.

Immediate cause of death	Duration
Cerebral Embolism	
Due to Diabetes mellitus and Arteriosclerosis (generalized.)	
Due to	
Other Conditions Gangrene of left foot	

(Include pregnancy within 3 months of death)

Date of operation March 2, 1945

Major findings of operation: Gangrene of left foot.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Ayers M. D.
Address 1514 Division St. Date signed 3/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

627250 Florence Young ✓ 627250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Oxford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Oxford St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Florence Young

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/26/45 12/1904

8. AGE: Years	Months	Days	If less than one day
30	3		hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ruth Green
(b) Address 521 Oxford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (d) MAR 27 1945 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1945 to 3/26 1945 and that I last saw h.er alive on 3/26/ 1945

Immediate cause of death	Duration
Cerebral embolism	6 hrs
Rt. Heart failure	2 days
Due to Nitural Insufficiency	3 yrs.
Bronchitis	Chronic
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature R. Louis Young Jr. M. D.
Address 100 Druid Hill Ave Date signed 3/26/45

VS 3

G27251 ✓ G27251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 687 Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 687 Mulberry St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nathiniel Bailey | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-79

8. AGE: Years 66 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace A. A. Co., Md. (Severn)
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Adel Powell
(b) Address Daughter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) MAR 27 1945 (Date received) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1941, to March 26 1945, and that I last saw h[illegible] alive on 3/26 1945.

Immediate cause of death	Duration
Cardio Vascular Renal disease	Indefinite
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Woodland M. D.
861 Harlem Ave. Date signed 3/26/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27252 X V G27252

G27252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1222

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lynette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Spring Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Salisbury Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida V Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 9 1868

8. AGE: Years 61 Months 7 Days 16 If less than one day hr. min.

9. Birthplace Sykesville (Town, county, and state) Md.

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name George Collins
13. Birthplace Carroll Co Md

MOTHER 14. Maiden Name Ellen Elder
15. Birthplace Carroll Co Md

16 (a) Informant Charles A Martin
(b) Address 3014 Salisbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28 45 (month) (day) (year)

(c) Cemetery or crematory Oaklawn Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2727 Edmondson Ave

19 (a) MAR 27 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1945, at 11.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1945, to 3/25 1945, and that I last saw he.x alive on 3/25 1945

Immediate cause of death Coronary Occlusion

Duration

Due to Coronary Sclerosis

Due to Coronary insufficiency of transmyocardial circulation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/22/45

Major findings of operation: Coronary thrombosis myocardial hypoxia

of autopsy Coronary Sclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.

Address Franklin Square Hospital Date signed 3/25/45

X

627253 627253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes) or (No)
If yes, name country

3 (a) FULL NAME Robert E. Volkmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife: late Caroline W Schlendorf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1882

8. AGE: Years 62 | Months 10 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Restaurant owner

11. Industry or business Restaurant

FATHER
12. Name Adam Volkmer
13. Birthplace Austria

MOTHER
14. Maiden Name Natalida Schauer
15. Birthplace Austria

16 (a) Informant Louis Volkmer
(b) Address 700 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry W. Fisher
(b) Address 4101 Edmondson Ave Huntington Williams, Inc.

19 (a) (b) Registrar

MAR 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1945, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945 to 3/25 1945 and that I last saw h/m alive on 3/24 1945

Immediate cause of death: Intracranial hemorrhage — Duration

Due to

Due to

Other Conditions: myocardial infarct-old, pulmonary congestion, hydrothorax right
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Wirt Hillegas, M. D.

Address Date signed

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83 (C27254)

C27254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Ave
(c) Hospital or institution Hospital St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 West Stiles Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Stela Kowaleski (KOWALEWSKI)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife late Anthony A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22, 1884

8. AGE: Years 60 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Kurowski
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Anne Andrzejack
15. Birthplace Germany

16 (a) Informant Mr. Charles A. Kowaleski
(b) Address 1605 North Gate Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location 1300 Dundalk Ave

18 (a) Funeral director Harry A. Wittee
(b) Address 410 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945 to 3/26 1945, and that I last saw h[illegible] alive on 3/26 1945

Immediate cause of death Coronary - Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cecil Reich, M.D.
Address 2[illegible] Gwynn Oak Ave Date signed 3/26/45

correct age is especially important. Physicians: please write the

G27255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27255 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILHELMINA DALBEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife James H. Dalbey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	3	hr. min.

9. Birthplace Bohemia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Rysanek
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Senfluk
15. Birthplace Bohemia

16 (a) Informant Mrs. Anna C. Leake
(b) Address 1926 Walbrook Ave.

17 (a) Burial (b) Date thereof 3/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Nat'l. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 27 1945 (b)
(Date received by Registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944 to March 26 1945.
and that I last saw h[illegible] alive on March 26 19 45.

Immediate cause of death: Acute Hypostatic Pneumonitis + Renal Failure — Duration: 3 days 3 days unknown

Due to: Chronic Cardio Vascular renal disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Leahman M.D.
Address 1926 Walbrook Ave Date signed 3/28/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

627256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Valley ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Carol Buchanan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Child

6 (b) Name of husband or wife ←

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1945

8. AGE: Years	Months	Days	If less than one day
	2	9	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Joseph E. Buchanan
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary A. Lanasa
15. Birthplace Baltimore Co. Md

16 (a) Informant Mr. Joseph E. Buchanan
(b) Address 1203 Valley St.

17 (a) Burial (b) Date thereof Mar 27 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayr Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Conkli & Son
(b) Address 924 E. Eager St

19 (a) MAR 27 1945 (b) Huntingtn Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1945, at 1.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1945, to 3-25 1945, and that I last saw her alive on 3-25 1945

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature M. E. Robertson
Address St Josephs Hosp. Date signed M. D. 3-25-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

27257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G-27257

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 E. 33rd. Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 E 33rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MERVYN LONG ANDREWS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Elizabeth Andrews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1898

8. AGE: Years	Months	Days	If less than one day
46	9	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Jobber
11. Industry or business Tobacco Business

FATHER
12. Name John Andrews
13. Birthplace Penna

MOTHER
14. Maiden Name Mary Wallace
15. Birthplace Penna

16 (a) Informant Mrs M. Elizabeth Andrews
(b) Address 1719 E 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE? & BROADWAY

19 (a) MAR 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH March 25 1945, 8.30 A

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/45 19 to 3/25/45, and that I last saw him alive on 3/25/45

	Duration
Immediate cause of death Coronary Occlusion	3 Hours
Due to Thrombus	3 Hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. N. Hemmeter M. D.
Address 1710 E 33rd Street Date signed 3/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

7258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 ✓ Registered No. G 27258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Washington Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1890

8. AGE: Years 55 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Alfred A. Mitchell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Collins
15. Birthplace Balto. Co. Md.

16 (a) Informant Luther Mitchell
(b) Address 1504 Harlem Ave

17 (a) Burial (b) Date thereof March 27, 1945
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. A. Hallan
(b) Address 1631 Druid Hill Ave

MAR 27 1945 (Date rec'd by registrar) (b) Huntington for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 11:35 P M

21. I certify that death occurred on the date and hour stated above, that I attended deceased from Jan. 11 1945 to March 23 1945 and that I last saw him alive on March 23 1945

Immediate cause of death: Cardio Vascular Renal Disease — Duration 9

Due to — 1

Due to

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. B. Hughes
Address 1413 Druid Hill Ave Date March 26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G27259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G27259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 E. preston St
(c) Hospital or institution:
at Home 9/9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 E. preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa B. Kaunders

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joseph F. Kaunders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1877

8. AGE: Years 68 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Austria, Europe (Town, county, and state)

10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name Jacob Blacht
13. Birthplace Austria

MOTHER
14. Maiden Name Frances Klein
15. Birthplace Austria

16 (a) Informant Mrs. George B. Young (Daughter)
(b) Address 1436 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Edwin W. Conflin & Son
(b) Address 924 E. Eager St.

19 (a) (b) Huntington Williams, Md.

MAR 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24, 1945; at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-1945 to 3-24-1945, and that I last saw her alive on 3-23-1945

Immediate cause of death: Surgical Shock — Duration: 4 days
Due to: Fractures of right wrist and right hip — 4 days
Due to: Diabetes Mellitus, Arteriosclerotic C.V.D. Disease, Bell's palsy — Unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 3-6-45
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-21-45 at ? M
(c) Where did injury occur? Balto., (City or town) Md. (County) (State)
Did injury occur about home, on farm, industrial place, in public place? Home While at work? no. (Specify home, farm, or place)
(e) Means of injury Stumbled and fell.

23. Signature Theo B. Taylor M. D.
Address 2802 Harford Rd Date signed 3-26-45

Approved by Thomas J. Mackie, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G27260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Bella Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Dodge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace A. A. County, Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Marie Thomas
15. Birthplace A. A. County, Md.

16 (a) Informant Mrs. Della Bell
(b) Address 1513 Mosher St.

17 (a) Burial (b) Date thereof Mar. 28, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 27 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1945, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - I also con and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fabrizio M.D.
Medical Examiner.
Date signed 3/25/45

VS 151

G27261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Cor. Dukeland St
(c) Hospital or institution West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Gueil St #24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Mooney Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-15-1944

8. AGE: Years | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward J. Mooney
13. Birthplace Syracuse N.Y.

MOTHER
14. Maiden Name Harriet Ingraham
15. Birthplace Toledo Ohio

16 (a) Informant Edward J. Mooney
(b) Address 806 Gueil St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memp.
Location Taylor Ave

18 (a) Funeral director Chas C. Miller Inc.
(b) Address 2435 E. Oliver St

19 MAR 27 1945 (Date rec'd by registrar) Huntington Williamsburg Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 3/25 1945 and that I last saw h[illegible] alive on 2/26 1945

Immediate cause of death Pneumonia R Ll — Duration 1 day

Due to Overwhelming infection, — Duration

Due to probably Septicemia — Duration 1 day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.
Address WB-6 A Date signed 3/25/45

Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

627262 ✓ 627262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95-1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 Keswick Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary Ellen Disselberger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis Disselberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-1879

8. AGE: Years: 65 | Months: 7 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER — 12. Name: John L. Richardson
13. Birthplace: Virginia

MOTHER — 14. Maiden Name: Mary Ford
15. Birthplace: Ireland

16 (a) Informant: Edward J. Disselberger
(b) Address: 3044 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 28-1945 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore Co. Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) MAR 27 1945 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25- 1945- at 12:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 19 , to Mar 25 1945 and that I last saw h[illegible] alive on March 24 1945:

	Duration
Immediate cause of death: Acute Cardiac Dilation	Dilation 2 yrs
Due to: Extremely high B.P.	
Due to: above	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H. B. McElroy, M.D.
Address: 2411 Fleet St. Date signed: 3/26/45

VS 150 For H. B. McElroy, by Howard J. Masters, M.D. X

correct age is especially important. Physicians: please write the

627263 627263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 0

Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the one which is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Elm Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Elm Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** D. Emory Markey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-42731

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A. Markey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28-1877

8. AGE: Years 67 Months 3 Days 26 If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER 12. Name Fulham Markey

13. Birthplace Maryland

MOTHER 14. Maiden Name Lydia Zencker

15. Birthplace Maryland

16 (a) Informant Mrs. Mary A. Markey

(b) Address 3702 Elm Avenue

17 (a) Burial (b) Date thereof March 27-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Marys (Hampden)

Location Baltimore, Maryland

18 (a) Funeral director Burgie Funeral Home

(b) Address 3631 Falls Road

19 (a) (Date received by registrar) (b) MAR 29 1945 Registrar

Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945 to 3/24 1945 and that I last saw h[illegible] alive on 3/24 1945.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerotic cardio-vascular-renal disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H. McFaul Jr. M. D.

Address 840 W. 36th St. Date signed 3/26/45

X

627264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 627264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Union Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Union Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Barton

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-03-5778

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 - 1879

8. AGE: Years 66 | Months 1 | Days 22 | If less than one day hr. mjn.

9. Birthplace Baltimore Maryland (town, county, and state)
10. Usual Occupation Textile Worker
11. Industry or business Wm. G. Hooper & Sons Co.

FATHER
12. Name Charles F. Barton
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Kelson
15. Birthplace Maryland

16 (a) Informant Mrs. Clara Estelle Turner
(b) Address 3608 Buena Vista Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29-1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Lambdin)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) MAR 27 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Mar 26 1945 and that I last saw him alive on Mar. 24 1945.

Immediate cause of death: Congestive Heart Failure — Duration
Due to: Arteriosclerotic C-V-R. Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis B. Bowman M. D.
Address 4037 Falls Rd. Date signed 3/26/45

VS 150

Instructions: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D 627265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 N Calvert St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur G. Hardesty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1871

8. AGE: Years	Months	Days	If less than one day
73	4	22	hr. min.

9. Birthplace Anne Arundel Co. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas O. Hardesty
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Crandall
15. Birthplace Maryland

16 (a) Informant Bessie Hardesty
(b) Address 3102 N. Calvert St.

17 (a) Burial (b) Date thereof 3/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudker
Location Edlesville Md.

18 (a) Funeral director T.A. Hardesty & Son
(b) Address Edlesville Md.

19 (a) MAR 27 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945 at 11:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to March 26 1945 and that I last saw him alive on March 26 1945.

Immediate cause of death	Duration
Cardio - Resp Failure	
Due to Arteriosclerotic Heart Disease	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 3/26/45
M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

627266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

452

627266 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mo16da
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Lyman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WILLIAM MCNICHOLAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW-1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1887

8. AGE: Years	Months	Days	If less than one day
58	1	26	hr. min.

9. Birthplace Texas, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. McNicholas
13. Birthplace Texas, Maryland

MOTHER
14. Maiden Name Mollie Price
15. Birthplace Texas, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof 3/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem
Location Lyons Creek Rd

18 (a) Funeral director John A. Hogan
(b) Address 300 E. Cobb St.

19 (a) MAR 27 1945 Registrar's office Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1945, 5:40a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1944 to Mar. 25, 1945, and that I last saw him alive on Mar. 25, 1945.

Immediate cause of death Squamous cell carcinoma of mouth with right cervical metastases — Duration 2 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
Address US Marine Hospital, Baltimore, Maryland Date signed 3/26/45

X

G27267

G27267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Beason St.
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Beason St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John. Baumgartner

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3249

4. Sex M.

5. Color or race White.

6 (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1877

8. AGE: Years 45 | Months 7 | Days — | If less than one day hr. min.

9. Birthplace Russia.
(Town, county, and state)

10. Usual Occupation Stevedore.

11. Industry or business

FATHER 12. Name Joseph. Baumgartner

13. Birthplace Unknown

MOTHER 14. Maiden Name unknown

15. Birthplace unknown.

16 (a) Informant Mrs. Mossman.

(b) Address 15-15 Beason St.

17 (a) Burial. (b) Date thereof 3-28-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location Langdale, Blvd.

18 (a) Funeral director Thos. F. Dill.

(b) Address 1524 Fort Ave.

19 (a) MAR 27 1945 (b) Huntington Woodlawn, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1945, to March 25 1945, and that I last saw h[illegible] alive on March 24 1945.

Immediate cause of death	Duration
Decompensated	6 days
Mitral Regurgitation	today
Due to Bronchiectasis	
Due to Chronic Interstitial Nephritis	6 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J F A Stevens

Address 878 Stanford Rd Date signed 3-27-45 M. D.

VS 150

correct age is especially important. Physicians: please write the

627268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931 D

627268 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W. Lanvale st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Color

6 (a) Single, married, widowed or divorced, Separated Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Lita Dorsey
(b) Address 1029 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore County

18 (a) Funeral director Ida Bailey
(b) Address 1421 E. Jefferson st.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 27 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1945 to March 25 1945 and that I last saw h alive on 19

	Duration
Immediate cause of death Arteriosclerosis	2 Years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Date signed 3-27-45

X

G27269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G27269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3640 Clipper Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Watkins.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. Watkins
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 26, 1900

8. AGE: Years	Months	Days	If less than one day
44	9	29	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Spence
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Quirk.
15. Birthplace Maryland.

16 (a) Informant Wm. Watkins
(b) Address 402 W 28th St

17 (a) Burial (b) Date thereof Mar 29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Old Frederick Road
18 (a) Funeral director Edward F. Moran
(b) Address 2615-17 Eastern Ave
19 (a) [illegible] (b) Huntington Williams, M.D.
(Date received) (Registrar) Registrar

MAR 27 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-1945 at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions General Arteriosclerosis
Nephrosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-26-45

927

G272.0

G272.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 137a

Registered No. .....

CWK-91069

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 137
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 3- 12
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore-Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 Clipper Heights Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George Vermillion

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife MARTHA VERMILLION
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 27-1874

8. AGE: Years	Months	Days	If less than one day
70	11	26	..... hr. ..... min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name John Vermillion (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?? (D)
15. Birthplace Maryland ??

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 27/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden
18 (a) Funeral director Cleveland & Donovan
(b) Address 3615-17 Eastern Ave.
19 (a) ..... (Date rec'd by registrar) (b) Interred in Holliswood

MAR 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 12:15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1944, to March 23 1945, and that I last saw him alive on March 23 1945.

Immediate cause of death	Duration
Uremia	3-4 wks
Due to Prostatic hypertrophy + urinary obstruction.	?
Due to	.....
Other conditions Arteriosclerotic heart disease	.....

(Include pregnancy within 3 months of death)

Date of operation 12-17-44, 12-30-44
Major findings of operation: Cystitis, Prostatic hypertrophy
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Houck E. Belton M. D.
Address Balt. City Hosp. Date signed 3/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27271

JO #89162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G27271 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos. 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 914 S. Sharp St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willa Mae McCaskill or Willie Mae McCaskill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1922

8. AGE: Years	Months	Days	If less than one day
23	-2-	18	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Karvey

13. Birthplace South Carolina

MOTHER

14. Maiden Name Latha Turkey or Turley

15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Co., Md

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W Montgomery St

19 (a) 3-27-1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 24, 1945, at 11:30M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26, 1944, to Mar. 24, 1945, and that I last saw her alive on Mar. 24, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis bilateral	10 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harold Dillon M.D.

Address Balto City Hosp. Date signed 3/26/45

G27272 G27272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 55 S Monastery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 55 S Monastery (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Stegman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1857

8. AGE: Years 87 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Anthony Schaefer
13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Jamon
15. Birthplace Germany

16 (a) Informant Fredk Stegman
(b) Address 55 S Monastery

17 (a) Burial Bernard (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director Geo E Fahey
(b) Address Fallon & Fayette

19 MAR 27 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 10:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1945 to March 25 1945, and that I last saw h.e.r. alive on March 25 1945.

Immediate cause of death	Duration
Congestive Heart Failure	2 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Callery M. D.
Address 3321 Frederick Date signed 3-26-45

Huntington Williams, M.D.

G27273 G27273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Avenue
(c) Hospital or institution: St. Agnes Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2139 Eagle St (Rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALEXANDER WORONOVICH

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
56 ?			hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name ? Woronovich

FATHER 13. Birthplace Russian

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace Russian

16 (a) Informant Irene Woronovich

(b) Address 2139 Eagle St

17 (a) Burial (b) Date thereof Mar. 28-45 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Holy Trinity Russian Location Stoney Run Md. ~9.9.

18 (a) Funeral director John G. Grebtauskas Jr.

(b) Address 423 S. Paca St

19 Mar 27 1945 Date rec'd by reg. Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1945, at 6.25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquisition and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Polycystic Disease of Kidneys

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John C. Davis M.D. Medical Examiner

Date signed 3/25/45

G27274 G27274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. House of Good Shepherd Mount and Hollins Sts
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth (LeBann) LEBEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1908

8. AGE: Years	Months	Days	If less than one day
36	9	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Leben
13. Birthplace

MOTHER
14. Maiden Name Josephine Leben
15. Birthplace

16 (a) Informant Mr. William Pugh
(b) Address Essex, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) MAR 27 1945 (Date rec'd by registrar) (b) Henrietta Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1945, at 3-05 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Multiple Perforations of Intestines — Compound Fracture of

Other Conditions Lumbar Vertebrae — Multiple Rib Fractures & hemothorax (Lt) — Fractured Pelvis and Ankle
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3/24/45 about 2 P.M.
(b) Where did injury occur? Mount and Hollins Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Good Shepherd Convent While at work?
(d) Means of injury Fell 4 floors while washing windows

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 3/29/45

G27275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 S. Patterson Pk Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Stephen (Szczepan) Antkowiak

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 21-1871

8. AGE: Years 74 | Months 5 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Painter

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace ?

MOTHER 14. Maiden Name Unknown

15. Birthplace ?

16 (a) Informant Anna Antkowiak

(b) Address 507 S Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Dundalk Ave

18 (a) Funeral director John J. Duda

(b) Address 2629 Hudson St.

19 (a) (b) Registrar

Date received by registrar Huntington Williams, M.D.

AR 27345 VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 25 1946 and that I last saw him alive on March 25 1946.

Immediate cause of death: Cerebral apoplexy — Duration: acute

Due to: Cerebral arterio Sclerosis ?

Due to: Chr. Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 5007 Pratt St Date signed 3/26/46

X

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

G27276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27276 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Gough St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Grazia Gigliotti

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~deceased~~ late Gennaro Gigliotti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1868

8. AGE: Years 76 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Praticello Italy
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business home

FATHER
12. Name Filippo Marasco
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Tomaino
15. Birthplace Italy

16 (a) Informant Anthony Gigliotti (Son)
(b) Address 502 S. Rappolla St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sacred Heart
Location German Hill Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) 3-27-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-45 19 , at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1944, to 3-26-1945, and that I last saw h[illegible] alive on 3-25 1945.

Immediate cause of death: Cerebral embolism
Due to: Cardiovascular disease
Due to: Cerebral arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place). While at work?
(e) Means of injury

23. Signature John Constantine, M.D.
Address 134 S. Conkling St. Date signed 3 1945

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G27277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27277 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hosp

(c) Hospital or institution: 2208 Hemmenway Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2218 Hemmenway Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August L. Brandner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rosalie Brandner

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Sheet Metal

11. Industry or business

FATHER 12. Name Frederick Brandner

13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know

15. Birthplace Germany

16 (a) Informant Louis Brandner

(b) Address 124 Rose Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30 (month) (day) (year)

(c) Cemetery or crematory Balto Mem Co

Location City

18 (a) Funeral director Ellicott Funeral Home

(b) Address 220 S Arlington St

19 (a) MAR 27 1945 (Date rec'd by registrar) (b) Huntington Millington Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945 to 3/26 1945, and that I last saw h. alive on 1945

Immediate cause of death Heart failure & coronary thrombosis

Due to Hypertensive Art. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Melvin Brodell M. D.

Address 3 Sinai Hospital Date signed 3/27/45

Melvin Brodell X

G27278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 South Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSWINKLE, MRS. ELLEN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-73

8. AGE: Years	Months	Days	If less than one day
72	1 mo	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Home work

11. Industry or business

FATHER
12. Name Tharwood, George.
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Shaffer, Julia
15. Birthplace Maryland.

16 (a) Informant James Batchelor
(b) Address 411 S Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location Catonsville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

19 (a) MAR 27 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1945, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1945, to 3-24 1945, and that I last saw her alive on 3-24 1945.

Immediate cause of death	Duration
Cerebral sarcoma	?
decompensation due to	
Hypertensive cardio vascular disease	?
Due to	
Due to	
Other Conditions Complete large bowel obstruction due to metastasis	1 wk

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Barkman M. D.
Address Church Home & Hospital Date signed 3-28-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

627279 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Homestead
(d) Street No. 605 Sr. Powatous Rd. (If rural give location) 605
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] HARTLOVE (MARGARET E.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles B. Hartlove

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22. 1896

8. AGE: Years 49 | Months 1 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Robert Byus
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Carrie Lamaker
15. Birthplace Baltimore, Maryland

16 (a) Informant Charles B. Hartlove
(b) Address 605 Sr. Powatous Rd., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location [redacted]

18 (a) Funeral director Ellis & Sons Funeral Home
(b) Address 2004 E. Oliver St

19 (a) MAR 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1945, at 1:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1945 to Mar. 26 1945, and that I last saw her alive on Mar. 26 1945.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Cerebrovascular accident (Possible cerebral embolism)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Grove M. D.
Address Union Memorial Hosp. Date signed 3-26-45

X

G27280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. G27280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 Brindon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Brindon
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Marie Ludwig

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm Ludwig

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Leo Koehler
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Kreitler
15. Birthplace Balto

16 (a) Informant Wm Ludwig
(b) Address 2806 Brindon Ave

17 (a) Burial (b) Date thereof March 28 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location City

18 (a) Funeral director Tellrich Funeral Home
(b) Address 2004 E. Oliver St

19 MAR 27 1945 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 19__, to Mar. 25. 1945, and that I last saw h__ alive on Mar 23 1945.

Immediate cause of death: Carcinoma of Colon. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1941

Major findings of operation: Annulare Carcinoma of Transverse colon.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Boyle, M.D.

Address 5217 Harford Rd. Date signed 3/26/45

X

627281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 627281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1685 Darley ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1685 Darley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Joseph T. Daniels

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ella Dare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1869

8. AGE: Years	Months	Days	If less than one day
76		13	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business

FATHER 12. Name Joe Daniels
13. Birthplace Md

MOTHER 14. Maiden Name Katherine Ferguson
15. Birthplace Pa

16 (a) Informant Mother (Name)
(b) Address 1685 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

19 (Date received by registrar) MAR 27 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25 1945, at 10 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944, to 3/25 1945, and that I last saw h[illegible] alive on 3-25 1945

Immediate cause of death	Duration
Myocardial degeneration	three week
Due to	
Due to Hypertension	2 yrs
Mitral Stenosis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Miller M. D.
Address 1500 N Broadway Date signed

X

Please fill in all items clearly and legibly. Physicians: please write the correct age is especially important. [illegible]

1945 G27482 1873

3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27482 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Dillon
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto-md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Dillon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mc Hugh Mc Donough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Mc Donough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 - 1873

8. AGE: Years 72 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Lawrence Mc Hugh
13. Birthplace Ireland
14. Maiden Name Anna Knight
15. Birthplace Ireland

16 (a) Informant Annd Davis
(b) Address 6704 Fait AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2518 E. Balto St

19 MAR 27 1945 (Date received by Registrar) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1945 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1935 to 3-25 1945, and that I last saw h- alive on 3-25 1945.

Immediate cause of death Chr. Myocarditis — Duration 4 years 2

Due to Cerebral Hemorrhage — 10 yrs

Due to Cerebral arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern Ave Date signed 3-25-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G27283 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2607 Beechland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Beechland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna V. Barbagallo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frank Barbagallo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2nd 1895

8. AGE: Years 49 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Mandello
13. Birthplace Italy

MOTHER
14. Maiden Name Angelina Castro
15. Birthplace Italy

16 (a) Informant Husband
(b) Address 2607 Beechland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2518 E. Baltimore St.

19 (a) (Date rec'd by registrar) MAR 27 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1942 to Mar. 25 1945 and that I last saw h[illegible] alive on March 25 1945.

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions: Bronchial asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Bruff
Address 1331 Chorth Ave Date signed 3-28-45

VS 150

G27284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G27284 Registered No.

Correct age if capacity imperative. If unknown, state approximate. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Akers

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-24-5382

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	

6 (b) Name of husband or wife Walter Akers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Ft Johns Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

PARENTS

FATHER
12. Name Frank Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Lena Cephas
15. Birthplace Md

16 (a) Informant Lena Jackson
(b) Address 1234 Penna Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof Mch 29-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) MAR 27 1945 Huntington Williams, M.D.
(Date of this registration) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 8 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Embolism

Due to Vegetative arteritis
Syphilitic arteritis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed March 26 1945

G27285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G27285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Saratoga St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Johnson Baby Daisy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-45

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Balto md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace Clinton S.C.

MOTHER
14. Maiden Name Daisy Chapman
15. Birthplace Greenville S.C.

16 (a) Informant Daisy Johnson
(b) Address 620 W. Saratoga St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAR 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 27 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1945, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945, to 2-10-1945, and that I last saw him alive on 2-10-1945.

Immediate cause of death	Duration
Due to Prematurity	31 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Perry Peter M.D.
Address Provident Hosp Date signed 3/27/45

2613

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27286
AB-92685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G27286
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raleigh Askew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19-1902

8. AGE: Years	Months	Days	If less than one day
42	4	6	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Turner Askew
13. Birthplace N.C.

MOTHER
14. Maiden Name Minnie (D) Roberta Gant
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof March '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shipped to
Location Cofield, N. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 122 N. Schroeder St.

19 (a) MAR 27 1945 (b) Huntington, W. Va.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25- 1945, at 8P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21- 1945 to 3-25 1945, and that I last saw h 1m alive on 3-25- 1945

	Duration
Immediate cause of death Uremia	?
Due to hypertensive cardiovascular renal disease	
Due to	
Other Conditions Pneumonia & empyema, cirrhosis of liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address City Hosp. Date signed 3-27

1310

G27287
3 d Birth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G27287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene St.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Ramsey St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Myers
3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-01-5196

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of husband or wife [illegible] Myers
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1879

8. AGE: Years	Months	Days	If less than one day
65	6	21	hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Upholstery
11. Industry or business Geo. Spindler Co.

FATHER
12. Name Charles Myers
13. Birthplace Md

MOTHER
14. Maiden Name Alice White
15. Birthplace

16 (a) Informant Self / Stone & Myers
(b) Address 1915 Ramsey Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Geo. P. Schurt
(b) Address 3101 Frederick Avenue

19 (a) (Date rec'd by registrar) MAR 27 1945 (b) Registrar Hunting for William H. Hall

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1945, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1945 to 3-25 1945 and that I last saw h. l. m. alive on 3-24 1945

Immediate cause of death Inanition — Duration

Due to C.A. esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3-24-45
Major findings of operation: gastrostomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. M. Bourne M. D.
Address 1101 Eutaw Pl. Date signed 3-25-45

X

Please write plainly, with unfading ink. Spelling of names, and information about the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

(2) G27288

GRiisseR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

G27288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S Payson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Mary Griisser

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Griisser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1908

8. AGE: Years 36 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Ind (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Tyler

13. Birthplace Maryland

MOTHER 14. Maiden Name Juliet Agnes

15. Birthplace Maryland

16 (a) Informant Henry Griisser

(b) Address 326 S. Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28, 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Anne Arundel County, Md.

18 (a) Funeral director Geo. D. Schwab

(b) Address 2101 Frederick Avenue

19 (a) (Date received by registrar) MAR 27 1945 (b) Huntington Building Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945, to 3/26 1945 and that I last saw h[illegible] alive on 3/26 1945

Immediate cause of death Cerebral Embolism — Duration

Due to Rheumatic C-V-D.

Due to Dehydration & Severe Anemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac Valve Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Reinhardt, Jr. M.D. M. D.

Address St. Agnes Hosp Date signed 3/26/45

G27289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G27289
Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be given. Use a typewriter if convenient. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 years 4 mos 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years 4 mos 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Dalton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend Patrick E. Carey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1871

8. AGE: Years 73 | Months 5 | Days 4 5 | If less than one day 17 hr. 55 min.

9. Birthplace Spencer, Mass.
(Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name Patrick Carey
13. Birthplace Spencer, Mass.

MOTHER
14. Maiden Name Mary Kennedy
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road - Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary & St. Mary's
Location Worcester, Mass.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOGDEN SUC.) 108 N. NORTH AVENUE

19 (a) (Date received by registrar) MAR 27 1945 (b) Registrar Huntington

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1939, to March 26 1945 and that I last saw him alive on March 26 1945

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
General Arteriosclerosis — Diabetes
Due to: Mellitus — 5 yrs
Due to:
Other Conditions: Dyspnoea with Arteriosclerosis — 5 yrs 5 Mos
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Alagia M. D.
Address 33 W. Eastern Ave Date signed

G27290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1220

G27290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene St.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Mitchellville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George C Savage

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of ~~husband or~~ wife Rebecca Savage
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 60 | Months — | Days — | If less than one day — hr. — min.
9. Birthplace England (Town, county, and state)
10. Usual Occupation store keeper
11. Industry or business

FATHER
12. Name John Savage
13. Birthplace Ireland

MOTHER
14. Maiden Name Louise Bailey
15. Birthplace England

16 (a) Informant self
(b) Address Mitchellsville Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory Forest Grove Co. Md
Location
18 (a) Funeral director Robert Brothers
(b) Address Upper Marlboro, Md.
19 3-27-1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1945 to 3-27 1945, and that I last saw him alive on 3-26 1945.

Immediate cause of death Cardiac failure — Duration

Due to

Due to

Other Conditions ventral hernia repair
(Include pregnancy within 3 months of death)

Date of operation 3-16-45

Major findings of operation: ventral hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hall Bowie M. D.
Address Univ. Hosp. Date signed 3-27-45

X

G27291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benedetto or Benny Zungolo

3 (b) If veteran, name war

3 (c) Social Security Account No. 149-10-9955

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8 1885

8. AGE: Years: About 59 | Months: 7 | Days: 17 | If less than one day: hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Tailor shop

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela ?
15. Birthplace Italy

16 (a) Informant Rosario Galsano (Friend)
(b) Address 2512 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30 /45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Delaware Ave. Philadelphia

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) Date received by Registrar MAR 27 1945 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1945, at 10:02 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 3/24 1945, and that I last saw h. alive on 3/24 1945.

	Duration
Immediate cause of death Cardio Vascular Renal	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public Pa place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Tankle M. D.
Address 1500 Johnson Square Date signed 3/26/45

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

X

G27292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G27292 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. Tegeler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George F. Tegeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1871

8. AGE: Years	Months	Days	If less than one day
73	7	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George R. Leach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Shields
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. George F. Tegeler
(b) Address 1607 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Hilles Lamotte
(b) Address 1003 W. Baltimore St.

19 (a) MAR 27 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 9.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 24th. 1945, to Mar. 25th. 1945, and that I last saw her alive on ——— 19—

Immediate cause of death	Duration
Cerebral Hemorrhage	about 24 hrs.
Due to Arteriosclerosis	Unknown
Due to — — —	
Other Conditions ———	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Frogrogo M.D.
Address 401 E. 25th St. Date signed

VS 150

Affirmed by Howard J. Mendes, M.D. X

G27293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G27293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Bryant Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Bryant Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David E Moss

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-7764

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1883

8. AGE: Years 61 62 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Benjamin Moss
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Schless
15. Birthplace Russia

16 (a) Informant Mrs Dena Katzen
(b) Address 2207 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Rd HamiltomAve

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Registrar) (b) Huntington Williams, M.D.

MAR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 10 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Mar 26 1945, and that I last saw h. l. alive on 3/26 1945

Immediate cause of death Coronary Thrombosis — Duration Subs

Due to Hypertension Cardio-Vascular Disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum, M.D.
Address 726 E. Preston St Date signed 3/26/45

PLEASE WRITE PLAINLY, with ordinary pen and ink. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G. L. Hawkins
Labatt & Hardell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 27294
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 N. Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N. Belnord Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary G. Kokta (Body)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Joseph Kokta (Body) | 6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Sept. 14, 1896
8. AGE: Years 48 | Months 6 | Days 11 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Sicherer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Waronek
15. Birthplace Baltimore

16 (a) Informant Joseph Kokta
(b) Address 818 N. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Mark Brocht & Son
(b) Address 900 N. Chester St

19 (a) Huntington Williams, M.D. (Signature of registrar) Registrar

MAR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Mar 24 1945, and that I last saw h.er alive on Mar 24 1945

Immediate cause of death: Cerebral thrombosis | Duration Long
Due to Coronary occlusion | 6 hours
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. L. Hawkins M. D.
Address 18 Belnord Ave Date signed 3-26-45

Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G27295 X ✓ G27295

G27295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. Be sure that every question is answered and that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 years 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Same "

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Waltham (If outside city or town limits, write RURAL and give town)
(d) Street No. Newton Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Anna Julia Shea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1870

8. AGE: Years	Months	Days	If less than one day
74	4	11	12 hr. 30 min.

9. Birthplace Chelsea, Massachusetts (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name John O'Shea
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Moynihan
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)

(c) Cemetery or crematory Notre Dame De Namur
Location Shelbyville Rd

18 (a) Funeral director George A. Corpening
(b) Address Catonsville Md

19 (a) (Date received by local registrar) (b) Huntington-Williams Mort

MAR 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1928 to 3/27 1945. and that I last saw h[illegible] alive on 3/27 1945.

Immediate cause of death	Duration
Acute Cardio-Vascular Collapse	2 days
Due to arterio sclerosis	
Due to	
Other Conditions Schizophrenia - Paranoid Conditions	39 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Algeo M. D.
Address 33 Woodlawn Ave (Date signed)

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627296 54a

Registered No. 627296

627296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington D.C. (b) County
(c) City or town Wash. D.C.
(If outside city or town limits, write RURAL and give name of city or town)
(d) Street No. 1819 Kilbourne Place NW (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Susan Thompson
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) March 6, 1888

8. AGE: Years	Months	Days	If less than one day
57	0	21	hr. min.

9. Birthplace Binghamton, NY (Town, county, and state)
10. Usual Occupation Business Man
11. Industry or business Dairy

FATHER
12. Name Arthur Lee Thompson
13. Birthplace Binghamton, NY

MOTHER
14. Maiden Name Rachael Dorothea
15. Birthplace Binghamton, NY

16 (a) Informant Wife
(b) Address Washington DC.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director Wm J. Treber & Sons.
(b) Address No. 4 E. Pr. Ave. Balt. 12 Md.

19 (a) MAR 28 1945 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945 at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1945 to 3/27 1945 and that I last saw h[illegible] alive on 3/27 1945

Immediate cause of death Fulminating interstitial Pneumonia — Duration

Due to brain Tumor

Due to

Other Conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation 3/16/45

Major findings of operation: Glioma of frontal lobe

Date of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Thompson M. D.
Address Univ Hosp Balto. Md Date signed 3/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correctly as possible. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. 627297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry in each item is required. Information should be carefully obtained. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Provident Hosp Baltimore Md.
(b) Street address 1114 Division
(c) Hospital or institution Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1057 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie D Rhodes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Negro	Married.

6 (b) Name of husband or wife Alonzo Rhodes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20 1917

8. AGE: Years	Months	Days	If less than one day
27	4	5	hr. min.

9. Birthplace Darlington, S C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Darlington, S C.

MOTHER
14. Maiden Name Rebecca Lide
15. Birthplace Darlington, S C

16 (a) Informant Alonzo Rhodes
(b) Address 1057 W Lexington St.

17 (a) Burial (b) Date thereof Mar 27 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Florence
Location South Carolina

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 MAR 28 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1945 to 3/25 1945. And that I last saw h[illegible] alive on 3/25 1945.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation 3/8/45
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. M. E. Wilson M. D.
Address Provident Hosp. Date signed 3/27/45

VS 150

G27298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G27298 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST Joseph's Hosp 8

(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MAHONEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race Wh. | 6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 1/2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilson M. Mahoney
13. Birthplace Canton. New York.

MOTHER
14. Maiden Name Mary Pesler
15. Birthplace Harrisburg Pa

16 (a) Informant Wilson M. Mahoney
(b) Address 1605 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28-45 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location Harrisburg Pa.

18 (a) Funeral director John B Miller Inc.
(b) Address 2435 E. Oliver Street

19 (a) MAR 28 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945, at 12 38 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945 to March 28 1945 and that I last saw her alive on March 25 1945

Immediate cause of death Undetermined

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2 Gorgas Lane Date signed 3/29/45

VS 150

Instructions: Fill in all items. Use ink. Be sure information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27299 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi Lydia Haslett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Warren W. Haslett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Mansfield, Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business none

FATHER 12. Name William Grove
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Warren W. Haslett
(b) Address 4215 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) MAR 28 1945 Huntington Williams, M.D.
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 26, 1945 to March 26, 1945 and that I last saw her alive on 3-26-45 19 45.

Immediate cause of death Cerebro-Vascular Hemorrhage — Duration

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions Arteriosclerosis, Generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. D. Good III M.D.
M. D.
My address Women's Hospital Date signed 3-26-45

X

G27300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G27300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Linnard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Kirkwood

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna E. Kirkwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20 1880

8. AGE: Years	Months	Days	If less than one day
64	6	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Street Cleaner
11. Industry or business Balto. City

FATHER
12. Name Wm. H. Kirkwood
13. Birthplace Unknown

MOTHER
14. Maiden Name Augusta Sheibe
15. Birthplace Unknown

16 (a) Informant Mr. Robert G. Kirkwood
(b) Address 749 Linnard St.

17 (a) Burial (b) Date thereof 3/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 28 1945 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-45 19 , at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 3-27 19 45

Immediate cause of death Coronary Thrombosis

Due to arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Gleason M. D.
Address Univ. Hosp. Date signed 3-27-45

X

G27301 ✓ G27301

G27301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 Sulgrave Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Sulgrave Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA JEAN JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1855

8. AGE: Years	Months	Days	If less than one day
89	4	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Stephen W. Jones
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Susan M. Carter
15. Birthplace Balto., Md.

16 (a) Informant Miss Ida V. Jones
(b) Address 1918 Sulgrave Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) MAR 28 1945 (b) Huntington Williams, M.D.

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 5 1945 to MAR 26 1945 and that I last saw h[illegible] alive on MAR 26 1945

Immediate cause of death	Duration
Cerebral Hemmorhage	3/26/45
Due to	
Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 1818 Eutaw Place Date signed 3/27/45

627302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 627302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Louise Hildt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife J. Frank Hildt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1893

8. AGE: Years 52. | Months 2 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Ohio, Cincinnati (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name deft Leonard Figge

FATHER 13. Birthplace France

MOTHER 14. Maiden Name Emma L. Roming

MOTHER 15. Birthplace Md. Jessups

16 (a) Informant Husband

(b) Address 3503 Belvedere ave. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tipton's Sons

(b) Address Catonsville Md.

19 (a) MAR 28 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1945, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944 to Mar 27 1945, and that I last saw h[illegible] alive on Mar 27 19 45.

Immediate cause of death	Duration
~~Coronary Thrombosis~~ Carcinomas of Uterus	1½ yrs
Due to ~~Coronary Thrombosis~~	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1 yr ago.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Sweeney M. D.

Address Union Mem. Hosp. Date signed 3/27/45

X

G27303 G27303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 Francis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob A. Jean

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct. 1859
8. AGE: Years: 85 | Months: 5 | Days: | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired Patternmaker
11. Industry or business: B. & O. R. R.

FATHER
12. Name: George Jean
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Cassandra Walter
15. Birthplace: Unknown

16 (a) Informant: Mrs. Daisy Shelly
(b) Address: 4606 Sims Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945, at 1.45 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inspection thereon and from the evidence (Autopsy or Inquiry)
obtained by said Inspection find that said deceased came (Autopsy or Inquiry)
to his death on the day stated above.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G. McNally M.D. Medical Examiner.
Date signed 3/26/45

VS 6

G27304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27304
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. of Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Balto.
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. FIKRIDGE LANDING Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Plummer

3 (b) If veteran, name war —

3 (c) Social Security Account No. UNKNOWN

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Billie Plummer
nee Wellborn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1913

8. AGE: Years	Months	Days	If less than one day
31	6	9	hr. min.

9. Birthplace Gloustey Va
(Town, county, and state)
10. Usual Occupation Dock Man Supervisor
11. Industry or business Maryland Drydocks

FATHER
12. Name Edward Plummer
13. Birthplace Easton, Md

MOTHER
14. Maiden Name Sarah E. Sears
15. Birthplace Gloustey, Va

16 (a) Informant William Plummer
(b) Address 1406 W. 38th St. Norfolk Va

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof Mar 29, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Gloustey, Va

18 (a) Funeral director Thomas W. Dungateon
(b) Address Glen Burnie, Md.

19 (a) MAR 28 1945 (Date received by registrar) (b) Huntington Williamsburg

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27- 1945, at 8 35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Compound Comminuted Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-27- at between 6.30 & 7 A.M.
(b) Where did injury occur? Md. Dry Docks
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by crank of a crane

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-27-45

7305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111c

Registered No. 627305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Short Court (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME CHRISTINA TOWNS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 6/13/44

8. AGE: Years	Months	Days	If less than one day
	9	14	.....hr. .....min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Clifton Towns
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Eldora Moloch
15. Birthplace Baltimore, Md.

16 (a) Informant Eldora Moloch
(b) Address 1208 E. Short Court

17 (a) [redacted] Burial (b) Date thereof 3 28 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Anne Arundel Co. Md

18 (a) Funeral director Mrs. John Bailey
(b) Address 1421 Jefferson St

MAR 28 1945 (Signature) Wellington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1945 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to.....

Other Conditions /
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 27 1945

X

G27306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G27306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Ellsworth
(c) Hospital or institution: 9th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Ellsworth (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Clarke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hattie Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1889

8. AGE: Years 55 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Bethelehem Steel Company

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Sophia Watts
15. Birthplace Va

16 (a) Informant Hattie Clarke
(b) Address 1715 Ellsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location L. G. Co

18 (a) Funeral director Sam't. H. Chase Sons
(b) Address 638 N. Eutaw

19 MAR 28 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945 at 2 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-45 19 to 3-26- 1945 and that I last saw h[im] alive on 3- 25- 1945

Immediate cause of death: Carcinoma of the liver — Duration: ?
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Odom M. D.
Address 3126 23rd N Date signed 3-27-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G27307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G27307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Boss Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mark Harris
13. Birthplace N. C.

MOTHER 14. Maiden Name Nancy Kenny
15. Birthplace N. C.

16 (a) Informant Annie Harris
(b) Address 125 S. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/45 (month) (day) (year)
(c) Cemetery or crematory
Location Littleton, N. C

18 (a) Funeral director Elroy O. Wilson
(b) Address 1800 Bentley Ave

MAR 28 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 45 to March 27 1945 and that I last saw h[illegible] alive on March 26 1945.

Immediate cause of death Lobar Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Durward Silverstein M.D.

Address 21 S. Broadway Date signed 3/27/1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be correctly supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G27308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G27308 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 Etting
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Etting (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Domestic

6 (b) Name of husband or wife Ezekiel
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 6 2

8. AGE: Years 62 | Months Sept 15 | Days 11 | If less than one day 1882 hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Rolf Edmonds
13. Birthplace Va

MOTHER
14. Maiden Name Eliza Edmonds
15. Birthplace Va

16 (a) Informant Geneva Lee
(b) Address 1903 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. L. Kelson
(b) Address 1383 Pleasant St Hillsdale

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 28 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945 to March 26 1945.
and that I last saw h alive on 19

Immediate cause of death Cerebral Hemorrhage — Duration 2 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature
Address Date signed 3/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-27309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G-27309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 73 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Smithwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Amrhein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Johanna Amrhein
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 1st 1869

8. AGE: Years	Months	Days	If less than one day
75	9	25	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Cabinet maker
11. Industry or business

MOTHER / FATHER
12. Name Joseph Amrhein
13. Birthplace Germany
14. Maiden Name Catherine Bircher
15. Birthplace Germany

16 (a) Informant John A. Amrhein
(b) Address 100 Smithwood Ave Catonsville

17 (a) Burial (b) Date thereof 3/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director J. J. Gluckert & Son
(b) Address 650 W. Baltimore St
(c) Huntington Williams Mgr

Mar 28 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1945 to 3/26 1945; that I last saw him alive on 3/26 1945

Immediate cause of death Cardio Respiratory failure — Duration

Due to Arteriosclerotic Cardio Vascular Disease

Due to Bronchial Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Capt Robert H. Jr M. D.
Address St Agnes Hosp Date signed 3/27/45

X Fatality

VS 150

627310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. 627310

Use typewriter or ink. Print plainly. Fill in all blanks. If unknown, write unknown. Be sure to report all the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Fairfield Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Fortson

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.W. II	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Mildred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1913

8. AGE: Years	Months	Days	If less than one day
32	-	12	hr. min.

9. Birthplace Edgerton Lee, Georgia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Warren Fortson
13. Birthplace South Atlanta, Ga.

MOTHER
14. Maiden Name Minnie Armstrong
15. Birthplace Georgia

16 (a) Informant Robert L. Gaines
(b) Address 335 Freestman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-45 (month) (day) (year)
(c) Cemetery or crematory Anderson S.C.
Location S.C.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1308 Pressman St.

19 (a) MAR 28 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 25 at 11 P.M.
(b) Where did injury occur? Chesapeake Ave. & Vera St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed

23. Signature Robert L. Gaines M.D.
Medical Examiner.
Date signed March 26 1945

G27311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27311
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0 a
(e) Length of stay in Baltimore (yrs., mos., or days) ----

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Everett
(If outside city or town limits, write RURAL and give town)
(d) Street No. 74 Summer Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Messer

3 (b) If veteran, name war -----

3 (c) Social Security Account No. ----

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife -------

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1872

8. AGE: Years 72 ? | Months 6 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Massachusetts
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ---
13. Birthplace ---

MOTHER
14. Maiden Name ---
15. Birthplace ----

16 (a) Informant Mrs. William Tarr
(b) Address 74 Summer St. Everett Mass.

17 (a) Removal (b) Date thereof 3/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Everett, Mass.
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave
Huntington Williams Mgr

19 (a) MAR 28 1945 (b)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 45 - 8:30 at A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio - vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed March 28, 1945.

VS 151

627312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

Registered No. 627312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Balto. City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mercoli Nolan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location [redacted] PHYSICIANS MEDICAL SCHOOL MAR 27 1945

18 (a) Funeral director..... Commissioner of Health
(b) Address.....

19 MAR 28 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1945 at 2 05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Bronchitis Catarrh

Due to.....

Other Conditions Emphysema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-6-45

2617

7313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G27313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 W. Pratt ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 W. Pratt ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Puckett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
~60?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 28 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945; at 1:17 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Me death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration; Pulmonary emphysema

Due to

Other Conditions Fatty degeneration of Liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D.
Medical Examiner.
Date signed March 2 1945

2616

X

G27314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G27314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wilma Hotel Cathedral Rear St.
(If rural give location)
(e) Citizen of foreign country..... (Yes or No)
If yes, name country 900 Cathedral St.

3 (a) **FULL NAME** Leonard Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			..... hr. ..... min.

9. Birthplace..... (Town, county, and state).
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Local JOHN HOPKINS MEDICAL SCHOOL MAR 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) MAR 28 1945 H. Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, 8 20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Fractured Skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-9-45 at 8 P M.
(b) Where did injury occur? Wilma Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Fell down inside stairs

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 3-10-45

2618

G27315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G27315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sesson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 28 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

3819

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945 at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Chronic Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Taylor M.D.
Medical Examiner.
Date signed March 19 1945

G27316 LINNE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27316 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6411 Cedonia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 5
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6411 Cedonia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George August Linne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Josephine K. Linne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1872

8. AGE: Years	Months	Days	If less than one day
72	9		hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Josephine K. Linne
(b) Address 6411 Cedonia Ave

17 (a) Burial (b) Date thereof 3 31 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (b)
(Date received by Local Registrar) Huntington Williams Registrar

MAR 28 1945

VS 15?

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed March 28 1945

X

G27317 G27317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Stuart Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verne E. Shell

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 363-09-7599

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1879

8. AGE: Years	Months	Days	If less than one day
65	11	29	hr. min.

9. Birthplace Wayne City, Ill.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William V. Shell
13. Birthplace Wayne, Ill.

MOTHER
14. Maiden Name Addie Z. Robinson
15. Birthplace Old Washington, Ohio

16 (a) Informant William V. Shell
(b) Address Pikesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Wiggins Brooks Inc
(b) Address 1217 St. Paul Street

19 (a) MAR 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 5.20 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia Bilateral

Due to

Other Conditions Aneurysm Aorta
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. Gaby Medical Examiner.
Date signed 3/27/45

109

G27318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45D

G27318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 E. 27th Street
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 336 E. 27th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian H. Schaecher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
63	—	—	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name Christian H Schaecher

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Walders

15. Birthplace Baltimore Md

16 (a) Informant

(b) Address 336 E. 27th Street.

17 (a) Lowdon Park (Burial, cremation, or removal) (b) Date thereof 3-29-1945 (month) (day) (year)

(c) Cemetery or crematory Lowdon Park

Location —

18 (a) Funeral director Mary W Wedefield

(b) Address 501 E 32nd St

MAR 28 1945 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 8.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2, 1945, to Mar. 26, 1945, and that I last saw h[illegible] alive on Mar. 26, 1945.

Immediate cause of death	Duration
Carcinoma of the lower jaw.	2 years.
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: none.

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frank M. Ogden M. D.

Address 2701 N. Calvert St. Date signed Mar. 27, '45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

F 3D

627319 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 W. McHenry St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Julia Donnahow (DONNAHAW)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years: 60-about | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Alabama (Town, county, and state)
10. Usual Occupation: Superintendent Canton Baptist
11. Industry or business: State Mission Board Md Baptist
12. FATHER Name: Richard Donnahaw
13. Birthplace: Virginia
14. MOTHER Maiden Name: Anna Cloudis
15. Birthplace: Virginia
16 (a) Informant: W. Irvin Grisett
(b) Address: 1102 Fidelity Bldg.
17 (a) Burial: Burial, cremation, or removal (b) Date thereof: Mar. 29 45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Maryland
18 (a) Funeral director: Geo. L. Schwab
(b) Address: 2101 Frederick Ave.
19 (a) Date received: MAR 29 1945 (year) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 19 45 at 3:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mitral Stenosis Myocardial Degeneration
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Chester F. Smithson M.D. Medical Examiner.
Date signed 3/29/45

27340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G27320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 638 S. Monroe St
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 S Monroe St.
(If rural give location)
(e) Citizen of foreign country? N.A. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald F. Dailey
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillian Howard
15. Birthplace Maryland

16 (a) Informant Mrs. Catherine Dailey
(b) Address 530 S. Fulton Ave.

17 (a) Burial (b) Date thereof 3-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Md.

18 (a) Funeral director Leo F. Schwab
(b) Address 210 Frederick Ave
(Signature or address of registrar) Huntington Williams M.D.

19 (c) MAR 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 1945 to 3-27 1945 and that I last saw him alive on Mar 27, 1945.

Immediate cause of death Congenital Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clark Gollan M. D.
Address Md. Gen. Hosp. Date signed 3-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27321 Bookhultz

BALTIMORE CITY HEALTH DEPARTMENT 83a ✓ Registered No. 27321

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3538 Old Frederick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3538 Old Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bookhultz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or divorced Widowed

6 (b) Name of husband Joseph H. Bookhultz
6 (c) If alive, give age yrs

7. Birth date of deceased (mo., day, yr.) Feb 15th 1861

8. AGE: Years 84 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Unknown) Beitzel
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Joseph Bookhultz
(b) 408 St. Anna St. Elizabeth N.J.

17 (a) Burial (b) Date thereof 3/31/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paul St

MAR 29 1945 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1945, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1945, to 3/28 1945, and that I last saw h~~e~~ alive on 3/28 1945

Immediate cause of death	Duration
Left Cerebral Hemorrhage	6 days
Due to	
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Williams
Address 5346 Frederick Rd Date signed 3/29/45 M.D.

X

G27322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G27322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullaton. (If outside city or town limits, write RURAL and give town)
(d) Street No. Bridge Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

1. FULL NAME (Angela) Lena Bissell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife. 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1945

8. AGE: Years — Months — Days 1 If less than one day hr. min.

9. Birthplace Fullerton, Md. (Town, county, and state)

10. Usual Occupation 0

11. Industry or business 0

FATHER
12. Name William J. Bissell
13. Birthplace Maryland

MOTHER
14. Maiden Name Eloid May Monroe
15. Birthplace Virginia

16 (a) Informant Mrs H. Bissell
(b) Address Bridge Ave - Fullerton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/45 (month) (day) (year)

(c) Cemetery Hiss
Location Fullerton Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 29 1945 (Date rec'd by registrar) Huntingtor Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 6 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 27 1945, to Mar 28 1945, and that I last saw h. alive on Mar 28 1945

Immediate cause of death: Cardio-Resp. Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchiyah Spragins

Address U M H Date signed 3-28-45

VS 150

X

G27323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G27323 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division Street

(c) Hospital or institution: Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 519 Baker St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Benjamin Peters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Annie C. Peters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1899

8. AGE: Years	Months	Days	If less than one day
45	5	26	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Bellman

11. Industry or business

FATHER

12. Name James Peters

13. Birthplace Md

MOTHER

14. Maiden Name Ella West

15. Birthplace Md

16 (a) Informant Annie C. Peters

(b) Address 519 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Md

18 (a) Funeral director Geo. F. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williamson, Md

MAR 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1945, at 11:42 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1945, to 3/27 1945, and that I last saw him alive on 3/27 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature I. B. Higgins, M.D.

Address Provident Hospital Date signed 3/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where information should be entered, write correct word or figure. If none, write none. If unknown, write unknown. Where exact age is not known, write the nearest estimate. Where age is especially important. Physicians: please write the causes of death clearly and legibly.

G27324 G27324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 S. Clinton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 S. Clinton Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Sebastian Thorn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Ida (nee Krueger)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1875

8. AGE: Years	Months	Days	If less than one day
69 yrs.	6	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Ambrose Thorn
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emma Goldburn (daughter)
(b) Address 928 S. Clinton Street

17 (a) Burial (b) Date thereof 3/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Family~~ Mt. Carmel
Location O'Donnell St., Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (b) Huntington Williams M.D.
(Date received by Registrar) Registrar
MAR 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26 1945, at 2 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to Mar 26 1945 and that I last saw him alive on Mar 26 1945

Immediate cause of death	Duration
Uraemia due to Chr. Interstitial Nephritis	6-16-44
Due to Myocardial Failure	3-21-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Eisenhuth M. D.
Address 842 S. Ann Ave Date signed 3-28-45

X

Physicians: please write the causes of death clearly and legibly. Information concerning cause of death is especially important. Please see that it is correct

G27325 ✓ G27325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause to which death should be charged statistically. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Snow

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	widowed

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1867

8. AGE: Years	Months	Days	If less than one day
78		11	hr. min.

9. Birthplace N. C. ✓ (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ned Snow
13. Birthplace N.C.

MOTHER
14. Maiden Name Tempie Mull
15. Birthplace N.C.

16 (a) Informant Pearl Harris
(b) Address 1610 Lexington Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/29/45 (month) (day) (year)
(c) Cemetery or crematory
Location Woldon, North Carolina

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 108 W. Montgomery Street

19 (a) (Date rec'd by registrar) MAR 29 1945 (b) Huntingtown, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945; at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20, 1945, to 19, and that I last saw him alive on Mar. 20, 1945.

Immediate cause of death

Due to Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Bando M. D.

Address 2445 19th Ave. Date signed 3-27-45

G27326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 a

Registered No. G27326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 S Collington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Bala
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Michael Blum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13. 1856

8. AGE: Years 88 | Months 10 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Jarman
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Kuen
15. Birthplace Germany

16 (a) Informant Mrs Lee Weidinger
(b) Address 616 N Rose St

17 (a) Burial (b) Date thereof March 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (b) Registrar
(Date rec'd by registrar) MAR 29 1945 Huntington Wallace, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 6 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945, to 3/28 1945
and that I last saw her alive on 3/27 1945

Immediate cause of death Cerebral Hemorrhage

Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lankey M.D.

Address 441 N. Ellwood Ave Date signed 3/28/45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Brewer Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Redd

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May, 1881

8. AGE: Years	Months	Days	If less than one day
63	10		..... hr. ..... min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Blend
11. Industry or business

FATHER
12. Name Pety Redd
13. Birthplace S.C.

MOTHER
14. Maiden Name ?
15. Birthplace S.C.

16 (a) Informant Charley Redd
(b) Address 711 Penn Ave

17 (a) Burial (b) Date thereof 3-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 2[illegible] Reliance Hill Ave.

19 (a) MAR 29 (b) Huntington Wilson Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26- 19 45; at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 3-26-45

X

G27328

CWK-92758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G27328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0-1-24

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 551 Orchard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paulette Elizabeth Queen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2-1945

8. AGE: Years	Months	Days	If less than one day
0	1	24	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Stinney
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Serina Queen
15. Birthplace Maryland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 2/ Druid Hill Ave.

19 (a) MAR 29 1945 (b) Huntington for Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH March 26 1945, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945, to March 26 1945, and that I last saw her alive on March 26 1945

Immediate cause of death	Duration
Pneumonia	
Due to Staph. (?)	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton D. Germain Jr. M. D.
Address 1314 Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G27329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 N. Chester Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Chester St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ludwick Wiesprecht

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Victoria
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) aug 25 1871

8. AGE: Years	Months	Days	If less than one day
73 72	7	2	..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Wiesprecht
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Mrs. Victoria Wiesprecht
(b) Address 202 N. Chester street

17 (a) Burial (b) Date thereof March 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester St

19 MAR 29 1945 (Date rec'd by registrar) Huntington Williams Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945 to March 27 1945 and that I last saw h[illegible] alive on March 27 1945

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Chronic Myocarditis	2 yrs.
Due to Chronic Nephritis	3 yrs.
Other Conditions Hypertrophy of Prostate.	1 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Sprecher M.D.
Address 1807 Eastern Date signed 3-29-45

VS 150

X

Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G27330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Louisiana (b) County
(c) City or town New Orleans,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1663 N. Galvez Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED PICARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white-	Married

6 (b) Name of husband or wife Henrietta Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	6 9	hr. min.

9. Birthplace New Orleans, La.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Alfred Picard
13. Birthplace Texas

MOTHER
14. Maiden Name Louise Forrester
15. Birthplace New Orleans, Louisiana

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland 4-1-45

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location New Orleans La.

18 (a) Funeral director Lee Oder
(b) Address 4644 York Rd.

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar)

MAR 29 1945
No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945, at 12:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23, 1945, to Mar. 26, 1945, and that I last saw h im alive on March 26, 1945

Immediate cause of death	Duration
Bronchopneumonia	24 hour
Carcinoma of larynx	2½ yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F Jones M. D.
Address US Marine Hospital Date signed 3/26/45
Baltimore, Maryland

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627331 ✓ 627331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Riley Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months 60 | Days | If less than one day hr. min.

9. Birthplace Columbia, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Copper Works

FATHER 12. Name Charles Hudson

13. Birthplace S.C.

MOTHER 14. Maiden Name Texanna ——

15. Birthplace S.C.

16 (a) Informant Viola Hudson

(b) Address 934 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 30-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A.A. Co Md

18 (a) Funeral director James Astarp

(b) Address 142 Wotiell St

19 (a) MAR 29 1945 (Date received by registrar) Interment for Williams, Mattie

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1943 to March 26 1945 and that I last saw him alive on March 26 1945

Immediate cause of death: Myocardial Insufficiency — Duration 1 yr

Due to: Chr. Bright's Disease — 2 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry E. Wilson, M.D.

Address 3 E. Biddle Date signed 3-28-45

VS 150

27332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G27332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
(d) Street No. 210 N. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J. Giles

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Female
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 1-187[illegible]

8. AGE: Years 74 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace: Phila, Pa. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business:

FATHER
12. Name: Martin Mahon
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Rose Mahon
15. Birthplace: Ireland

16 (a) Informant: Harold Battey
(b) Address: 210 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory: New Balto.
Location: Old Frederick Rd

18 (a) Funeral director: John A. Mahon
(b) Address: 300 E. Balto. St.

MAR 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945, at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1943, to Mar. 27 1945, and that I last saw him alive on Mar 27 1945.

Immediate cause of death: Bronchopneumonia — Duration: 2 days
Acute Cardiac dilatation — 24 hrs.
Due to: Hypertensive cardiovascular disease — ? years
Due to: with auricular fibrillation and valvular heart disease

Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Anthony J. Thomas
Address: 4600 York Rd Date signed: M. 3 D. 28/45

VS 180

X

27333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

627333 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write Rural and give town)
(d) Street No. 3519 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes M. Butler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Michael P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19 - 1875

8. AGE: Years 69 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Michael Fridel
13. Birthplace Balto. Md.

MOTHER 14. Maiden name Mary E. Boenger
15. Birthplace Balto. Md.

16 (a) Informant Mary Agnes Butler
(b) Address 3519 E. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Belair Rd.

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balto St.

19 MAR 29 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/45 19 , at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944 to March 27 1945, and that I last saw her alive on March 27 1945.

Immediate cause of death	Duration
Coronary Occlusion	3/27/45
Due to Chr. Myocard. Dis	10/1944
Due to Diabetes Mellitus	1/1/44
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Rogner M.D.
Address 801 Kenwood Ave. Date signed 3/27/45

VS 150

627334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

627334 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Echodale Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Echodale Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora E. Heim

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Widow

6 (b) Name of husband or wife Michael A. Heim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1873

8. AGE: Years	Months	Days	If less than one day
71	10		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Nagle
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Brill
15. Birthplace Germany

16 (a) Informant Mrs. H. Meise
(b) Address 3903 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 2 45 (month) (day) (year)
(c) Cemetery or crematory Morsland Park
Location Balto. Co. Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 MAR 29 1945 (Date rec'd by registrar) (b) Essington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 9 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1945, to March 28 1945, and that I last saw her alive on March 28 1945.

Immediate cause of death Cardio-renal disease — Duration Yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Watts M. D.
Address 7601 Easton Ave. Date signed 3/29/45
Baltimore 24, Md

Please write plainly, with pen and ink. Be sure to record the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. 627335

Please write plainly, with ink. Every item of information must be answered to satisfy requirements of law. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Springfield Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Russell A. Warfield
3 (b) If veteran, name war —
3 (c) Social Security Account No. 147-03-6389
4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife. Dorothy W. Warfield
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) April 5, 1900
8. AGE: Years 44 | Months 11 | Days 23 | If less than one day ____hr. ____min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Inspector, Liberty Motors.
11. Industry or business —

FATHER
12. Name Charles A Warfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Ette M. Fish
15. Birthplace Maryland

16 (a) Informant Mrs Russell A. Warfield
(b) Address 718 Springfield Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North Ave. & Fla. Aves, Balto. Md.

19 MAR 29 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28- 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22- 1945 to 3-28- 1945 and that I last saw him alive on 3-28-1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3-26-45
Major findings of operation: Intestinal obstruction, due to adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Corne M. D.
Address Union Memorial Hospital Balto. 18, Md. Date signed 3-28-45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 627336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 W Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily E. Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Woodward Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1889

8. AGE: Years	Months	Days	If less than one day
56	1	3	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis E. Crouse
13. Birthplace Pa.

MOTHER
14. Maiden Name Fannie Wilhide
15. Birthplace Pa.

16 (a) Informant Mrs. Maude Kirschner
(b) Address 1009 W. Balto. St.

17 (a) Burial (b) Date thereof 3/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 29 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945, at 9 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941, to March 1945, and that I last saw h-er alive on March 27 1945.

Immediate cause of death Coronary Thrombosis — Duration 1 hr

Due to Arteriosclerotic CVD — Duration

Due to — Duration

Other Conditions Hypertension Multiple — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 6207 Dorchester Rd Date signed 3/29/45

93D

VS 150

Please write plainly, with unfading ink. Entry of information should be carefully supplied. Items of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G27337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1944 W. Lanvale St.
(c) Hospital or institution: 16 W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1944 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA ANN PORTER

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William M. Porter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1860

8. AGE: Years	Months	Days	If less than one day
84	3	8	hr. min.

9. Birthplace Woodstock, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Bauserman
13. Birthplace Va.

MOTHER
14. Maiden Name - Fetzer
15. Birthplace Va.

16 (a) Informant Mr. William W. Porter
(b) Address 1944 W. Lanvale St.

17 (a) Burial (b) Date thereof 3/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 29 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1945, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1939 to Mar 11 1945 and that I last saw h alive on Mar 11 1945

Immediate cause of death	Duration
Acute Cardiac Dil	1 dy
Due to Chr. Valvular Heart	
Due to Pneum	7
Other Conditions Hyp and Hy pertrophy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1520 E 33rd Date signed 3/29/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

27338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93B

G27338 Registered No. 9698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Cornelia Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1905

8. AGE: Years	Months	Days	If less than one day
39	7	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Samuel Evans
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace Md

16 (a) Informant Nancy Evans
(b) Address 1628 Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave

MAR 29 1945 (Date rec'd by registrar) Huntingtn for Williams Mgr (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-1945 at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27-1945 to 3-27-1945 and that I last saw her alive on 3-27-1945

Immediate cause of death Myocarditis

Due to

Due to

Other Conditions Hypertension + Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Saunders M. D.
Address 1024 N. Stricker Date signed 3-29-45

VS 150

OAddAM

G27339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 ✓ Registered No. G27339

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Md.
(b) Street address 1514 Division
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Oaddam
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Essex Co. Va.. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Richmond B. Oaddam
13. Birthplace Essex Co. Virginia

MOTHER
14. Maiden Name Martha B. Hedgeman
15. Birthplace Essex Co. Virginia

16 (a) Informant Provident Hospital
(b) Address 1514 Division St..

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 MAR 29 1945 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1945, at 1135 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1944 to 3/24 1945 and that I last saw him alive on 3/24 1945

Immediate cause of death Gangrene of the right foot
Due to Arteriosclerosis (generalized)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1/28/45
Major findings of operation: (Surgeon's Anatomy) Normal ganglion
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Ryan M. D.
Address Provident Hosp Date signed 3/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Information should be carefully sought for. Be sure to write the causes of death clearly and legibly. Ages, dates, and birthplaces must be stated. Do not use abbreviations. Do not state "unknown" if it is possible by any effort to obtain the correct age is especially important. Physicians: please write your signature exactly as you wish it to appear in your permanent records.

VS 150

G27340 ✓ G27340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1247 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Naomi Brandau

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) May 16, 1942

8. AGE: Years 2 | Months 10 | Days 13 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John R Brandau
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth Cassidy
15. Birthplace Balto., Md.

16 (a) Informant John R. Brandau
(b) Address 1247 E Lanvale St

17 (a) Burial (b) Date thereof 3/31/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lakewood
Location Taylor Ave Balto Co

18 (a) Funeral director George J Ruth Inc
(b) Address 1735 Hartford Ave

19 (a) MAR 29 1943 (b)
(Date rec'd by registrar) Lexington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

25

20. DATE OF DEATH March 27, 1945, at 6 A M

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed March 29 1945

* Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G27341

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Woman's Hospl 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21da.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yr 6mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W Cross, Sb.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Daly (MARY E DALY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife James Patrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1898

8. AGE: Years	Months	Days	If less than one day
46	7	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business -

FATHER
12. Name HARRY D HADEL
13. Birthplace BALTO MD

MOTHER
14. Maiden Name ANNIE LEWIS
15. Birthplace BALTO MD

16 (a) Informant Hospital Records
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN CEM
Location GLEN BURNIE MD

18 (a) Funeral director Bernard C Hank
(b) Address 121 E Lexington St Williamsport, Md

19 MAR 29 1945 (Registered by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 1P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/8 1945 to 3/28 1945, and that I last saw her alive on 3/28 1945.

Immediate cause of death	Duration
Cardio-respiratory arrest	
Due to Pulmonary edema	
Due to Congestive heart failure	
Other Conditions Carcinoma of bladder. Post-op shock	

(Include pregnancy within 3 months of death)

Date of operation 3/26/45

Major findings of operation: Carcinoma of bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest E. Banfield

Address Womans' Hosp. Date signed 3/28/45 M. D.

X - Banfield

G27342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 773 George St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 773 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Claudie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1900

8. AGE: Years 44 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Greenwood, S.C. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Saunders Wright

13. Birthplace Greenwood, S.C.

MOTHER 14. Maiden Name Carrie ??

15. Birthplace S.C.

16 (a) Informant Claudie Wright

(b) Address 773 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29, 1945 (month) (day) (year)

(c) Cemetery or crematory Family Location Lancaster Co. Va.

18 (a) Funeral director Chas. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) MAR 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945 at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1945 to March 27 1945 and that I last saw him alive on 3/26 1945

Immediate cause of death Coronary Occlusion — Duration 1 hr.

Due to Acute Pulmonary Edema — 1 hr.

Due to Arteriosclerosis

Other Conditions Chr. Nephritis and Hypertension — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ralph J. Young M. D.

Address 1717 E. Monument St. Date signed 3/29/45

920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 — G27343 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Carrollton Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Grace E. Whiting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1898

8. AGE: Years 47 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public schools

FATHER
12. Name Edward F. Whiting
13. Birthplace Middlesex Co. Va.

MOTHER
14. Maiden Name Ida M. Bayer
15. Birthplace New York, N.Y.

16 (a) Informant Murray E. Whiting
(b) Address 1117 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. A. Holland
(b) Address 9 [illegible]

MAR 29 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 23 1945 to Mar 25 1945 and that I last saw her alive on Mar 25, 1945.

Immediate cause of death	Duration
Tuberculous Peritonitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Borell M. D.
Address 608 N. Carrollton Ave. Date signed 3/27/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M. D. R. 1268-9

G27344

HEALTH DEPARTMENT—CITY OF BALTIMORE

G27344

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 3017 Tong Terrace St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 90 yrs. 1 mos. 4 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Annie Miriah Beck

(a) Residence: No. 3017 Tong Terrace St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles R. Beck

6. DATE OF BIRTH (month, day, year) Feb. 24, 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
90	1	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME George J. Roche

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Anne Jones

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Mrs. Helen H. Benson

(Address) 5209 Kenilworth Avenue

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place St. John's Date 3/30, 19 45

19. UNDERTAKER H. W. Meeks and Son

(Address) 805 N. Calvert Street

20. FILED MAR 29 1945, 19 Huntington White Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 28, 1945

22. I HEREBY CERTIFY, That I attended deceased from March 13, 1943 to March 28, 1945

I last saw her alive on March 28, 1945 Death is said to have occurred on the date stated above, at 1:30 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Broncho-pneumonia	7 days
Chr. Interstitial Nephritis	1935

Other contributory causes of importance:

Endocarditis	1930
Myocarditis	1940

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Carl H. Jensen M. D.

(Address) 5111 York Rd

BRIEF CAUSES OF DEATH in plain terms, so that OCCUPATION is very important. See instructions on back of certificate. Exact statements of the property concerned.

G27345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

+V 181

G27345 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution:
ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 77 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. JOPPA ROAD -14
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. JOHN EMGE (John L Emge)
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife Mary E. Emge
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/25/66
8. AGE: Years 78 Months 4 Days 4 2 If less than one day hr. min.
9. Birthplace BALTO. County (Town, county, and state)
10. Usual Occupation UNEMPLOYED.
11. Industry or business
FATHER 12. Name John Emge
13. Birthplace Germany
MOTHER 14. Maiden Name Martha ?
15. Birthplace Baltimore, Md.
16 (a) Informant Charles Emge (Brother)
(b) Address 9301 Harford Rd. Balto: Co
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.
18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
MAR 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945 at 4:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1945 to 3/27 1945, and that I last saw h[illegible] alive on 3/27 1945.
Immediate cause of death RESP. FAILURE DUE TO TETANUS — Duration
Due to 2ND DEGREE BURNS of RT. LOWER EXTREMITY
Due to
Other Conditions ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence March 8, 1945 at A.M.
(c) Where did injury occur? Joppa Road - Essex. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home ; While at work? [illegible]
(Specify kind of place)
(e) Means of injury [illegible] burning [illegible] caught on fire.
23. Signature Henry J. Hourihan M.D.
Address St. Jos. Hosp. Date signed 3/29/45

VS 150 For S/C J. Zubinski, by Howard H. Andrews, M.D.

FEMALE WHITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully obtained and correctly written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27346
469.082.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54a

G27346
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Garrett
(c) City or town Bittinger
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmer. Brenneman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-23

8. AGE: Years	Months	Days	If less than one day
21	3	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Simon Brenneman.
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Klog
15. Birthplace Md.

16 (a) Informant Friend.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Mch. 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bittinger Cem
Location Bittinger Md
18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place
19 (a) MAR 29 1945 (b) Huntington, W. Va.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at 6.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to March 29 1945, and that I last saw h[illegible] alive on March 29 1945.

Immediate cause of death: Brain Tumor — post operative.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months)

Duration
over

Date of operation Feb 21, 1945
Major findings of operation: Brain Tumor — Hard necrotic.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul W. Saunders
Address Johns Hopkins Hosp. Date signed 3/29/45

X

Typed or printed in black ink. Entries must be complete and correct as to all information required. Physicians: please write the causes of death clearly and legibly.

G27347

BALTIMORE CITY HEALTH DEPARTMENT X G27347

CERTIFICATE OF DEATH 47D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Canada

3 (a) FULL NAME ~~Vernon Montague~~ Cecil Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 76.

8. AGE: Years 69 68 | Months | Days | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name — TOWNSEND
13. Birthplace ENGLAND

MOTHER
14. Maiden Name Rosa —
15. Birthplace ENGLAND

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Royal Cemetery
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 1945, at 4 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 26 1945 to Mar 27 1945 and that I last saw him alive on Mar 27 1945.

Immediate cause of death	Duration
Generalized deterioration & Cachexia	
Due to Carcinomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurel Dobson Jr. M. D.
Address Johns Hopkins Date signed 3/28

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627348 — 1638 — Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 Gwynn Oak Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Le. Goudey (Goudy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married

6 (b) Name of husband or wife Donald N. Goudey
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1918

8. AGE: Years	Months	Days	If less than one day
26	4	6	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name Geo. W. Hogan
13. Birthplace Va.

MOTHER
14. Maiden Name Lucille C. Krause
15. Birthplace Va.

16 (a) Informant Donald N. Goudy
(b) Address 2125 Gwynn Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31 '45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto Co. Md.

18 (a) Funeral director John W. Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) Mar 28 1945 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbiturate Poisoning (Nembutal)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 25, 1945
(b) Where did injury occur? 2125 Gwynn Oak Ave
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Swallowed Nembutal

23. Signature Robert Le Gardner M.D. Medical Examiner
Date signed March 26 1945

~~627349~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

627349
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Institution: Rutland
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or ~~days~~) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 Lakeview Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maud Koenigsberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband: Harris Koenigsberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 1876

8. AGE: Years 68 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Abraham Wechsler
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Haiker
15. Birthplace New York

16 (a) Informant Mrs. B. Baumgarten
(b) Address 2421 Lakeview Ave.

17 (a) Burial (b) Date thereof 3/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) (b)

MAR 29 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1945, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1945 to 3/28 1945, and that I last saw h. alive on 3/27 1945.

Immediate cause of death: Cardio Resp Failure — Duration

Due to: Hypertensive Cardio Disease

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. Simon M.D.
Address Sinai Hospital Date signed 3/28/45

93D

PLEASE WRITE LEGIBLY. WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. Undertakers: please write correct age is especially important.

G273.0 ✓ G273.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lake Drive & Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Park Circle Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA S. LANSBURGH.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Max Lansburgh.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1853

8. AGE: Years 91 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Lewis Sonnehill.
13. Birthplace Bavaria.

MOTHER
14. Maiden Name Barbara Prag.
15. Birthplace Bavaria.

16 (a) Informant Miss. Adele Lansburgh,
(b) Address Park Circle Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3.30.45. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harid Sonnehsinn & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Registrar
MAR 29 1945 Huntington Williams, M.D.
VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch. 28th. 1945, at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 15 1945 to Mch. 28 1945. and that I last saw h.& alive on Mch 27 1945.

	Duration
Immediate cause of death Arteriosclerotic heart disease)	2 wks
Due to Coronary artery sclerosis	
Pulmonary Edema	2 weeks
Due to Generalized arteriosclerosis	
Other Conditions Hypertension	25 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

X

Please write or print plainly, with ink or indelible pencil. Do not use pencil. Be sure to answer every question, or insert the word none where it is applicable. Do not use ditto marks. Be sure to give the exact place of death and the correct residence of deceased. Be sure to fill in the time of death, the cause of death, and the correct age. Physicians: please write the causes of death clearly and legibly. This certificate is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27352

61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison Sts.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Villa Nova Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isidor Merfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Katie Merfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1860

8. AGE: Years 84 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business ?

FATHER
12. Name Joseph Merfeld,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rose ?
15. Birthplace Germany

16 (a) Informant Mr. Bernard Merfeld,
(b) Address Pikesville, Md.

17 Burial (Burial, cremation, or removal) (b) Date thereof 3/30/45
(month) (day) (year)
(c) Cemetery ~~or crematory~~ Har Sinai
Location Balto. Md.

18 (a) Funeral director Isaac Sondheim & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1945 Huntington Williams, M.D.

93D

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1945, at 8 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 3/27 1945, and that I last saw h~~e~~ alive on 3/27 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Hypertension & V. Disease	
Due to	
Other Conditions Chronic Nephritis, Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 3/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 627352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Gardner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/1942

8. AGE: Years	Months	Days	If less than one day
2	7	6	hr. min.

9. Birthplace Severna Park
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Mary Gardner
15. Birthplace Md.

16 (a) Informant Family
(b) Address Severna Park, Md.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven.
Location Glen Burnie, Md.

18 (a) Funeral director James H. McCardy
(b) Address No. E. Fayette St. Baltimore, Md.

19 (a) Filed (Date received by Registrar) MAR 29 1945 (b) Huntington Williamsville, Md. Registrar

MHS-15T

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 9:32 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death, in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural
Hematoma of Brain, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/27/45 at P. M.
(b) Where did injury occur? Severna Park
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Said to have fallen out of bed

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 28 1945

627353 ✓ 627353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No.

Write the causes of death clearly and legibly. Physicians: please write plainly. Typewriting is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address In front of 422 Evesham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Evesham Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Warren Preston

3 (b) If veteran, name war	3 (c) Social Security Account No.
11	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1897

8. AGE: Years	Months	Days	If less than one day
47	3	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Asb. Removal
11. Industry or business

FATHER
12. Name Benj. Preston
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Johnson
15. Birthplace Md.

16 (a) Informant Family
(b) Address 223 Oakleigh Village

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory Abingdon Meml. Gdns.
Location Abingdon Md.

18 (a) Funeral director J. L. McCully
(b) Address 30 E. Fort Ave

19 (a) MAR 29 1945 (Date rec'd by Registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 7:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Laceration of bowel & bruise.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-28-45? at a. M.
(b) Where did injury occur? Front of 422 Evesham Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Blunt Force

23. Signature Howard J. Madison M.D. (Medical Examiner)
Date signed 3-28-45

VS 151

G27354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G27354
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Burleith Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3306 Burleith Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie H. Leslie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Geo. Leslie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 5-1884

8. AGE: Years 60 | Months 11 | Days 27 | If less than one day — hr. — min.

9. Birthplace New York City, N. Y.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Accounting Clerk

FATHER
12. Name Max Hirschhausen
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Thomas
15. Birthplace Germany

16 (a) Informant Daughter Marge
(b) Address 3306 Burleith Ave

17 (a) Removal (b) Date thereof 3/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairmount Cem.
Location Newark, N. J.

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address Baltimore, Maryland

29 1945 (Date received by registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 yrs 19— to May 29 1945 and that I last saw her alive on Mar 24 1945

Immediate cause of death	Duration
Chronic myocarditis	15 yrs
Due to Hypertension	15 yrs
Due to Diabetes	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C M Bergerett
Address 3455 Pk Heights Ave Date signed 3/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27355 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave.
(c) Hospital or institution:
Hood Nursing Home 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH KNIGHT

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles T. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 20, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	9	hr. min.

9. Birthplace: Scranton, Pa.
(Town, county, and state)

10. Usual Occupation: School Teacher (retired)

11. Industry or business

FATHER
12. Name: Richard Robinson
13. Birthplace: England

MOTHER
14. Maiden Name: Ann Harrison
15. Birthplace: England

16 (a) Informant: Ronald C. Jones Pa.
(b) Address: 427 Madison Ave., Scranton 10,

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/29/45 (month) (day) (year)
(c) Cemetery or crematory: Forest Hill
Location: Scranton, Pa.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md

19 (a) (b) (Signature of Registrar) Registrar

MAR 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1945 at 10:00 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Mar 29 1945, and that I last saw h.. alive on Mar 28 1945

Immediate cause of death	Duration
Degeneration Cardiac Vascular Disease	3 wks
Due to	
Due to	
Other Conditions Depressive Psychosis	2 years

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Hinkel M. D.
Address Balto 28 Date signed 3/29

X

G27356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27356 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Chesterfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Chesterfield
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Wilson

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Grace M Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1892

8. AGE: Years 52 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Lineman Edgewood Arsenal
11. Industry or business

FATHER
12. Name Alec Wilson
13. Birthplace Scotland

MOTHER
14. Maiden Name Cora Erskine
15. Birthplace Indianna

16 (a) Informant Mrs Grace Wilson
(b) Address 3010 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location ~~Ulrich Funeral Home~~ Ulrich Funeral Home

18 (a) Funeral director ~~Ulrich Funeral Home~~
(b) Address 2008 Orleans St

19 (a) MAR 29 1945 (b) Hunting for Mr. [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945 at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to March 27 1945, and that I last saw him alive on March 27 1945

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Arteriosclerosis moderate.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Shannon Drive
Date signed 3/29/45

G27357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G27357 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Walbrook
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Winslow Road
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Burton Lane Bostwick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Edith Bowling
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 7. 1897

8. AGE: Years	Months	Days	If less than one day
47	7	22	--hr. ---min.

9. Birthplace Easton, Maryland
(Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business -------

FATHER
12. Name Burton Loomis Bostwick
13. Birthplace Ohio

MOTHER
14. Maiden Name Fannie Lane
15. Birthplace Easton, Md.

16 (a) Informant Mrs. Edith B. Bostwick
(b) Address 4515 Wilmslow Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meatt and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 29 1945 (Date rec'd by registrar) (b) Huntington Williams Mgr.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945, at 5:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 28 1945 11 P M.
(b) Where did injury occur? Overhill Road nr Keswick
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck on head

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 29 1945

G27358 X over G27358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany Co.
(c) City or town Orchard Beach.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albertie Galford Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			17 hr. min.

9. Birthplace Orchard Beach Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert Lee Galford Sr

13. Birthplace W. Va.

MOTHER 14. Maiden Name Jewel Hoage

15. Birthplace W. Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 28 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 29 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

35

20. DATE OF DEATH 3-23 1945 at 12.5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1945 to 3-23 1945, and that I last saw h. alive on 3-23 1945

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sub arachnoid ham

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M.D.

Address JHH Date signed 3-26

2620

159

G27359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G27359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 W. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 W. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara B. Owen

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~ widowed, or ~~divorced~~. Widowed

6 (b) Name of husband or ~~wife~~ Joseph Owen

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace N. Y.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name John E. Collins
13. Birthplace Unknown

MOTHER
14. Maiden Name Katherine Cashell
15. Birthplace At Sea

16 (a) Informant Sara E. Owen
(b) Address 220 W. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/45 (month) (day) (year)

(c) Cemetery ~~crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

MAR 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 1945, at 3 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944, to Mar 27 1945, and that I last saw her alive on Mar 26 1945.

Immediate cause of death Myocardial Insufficiency

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration of Illness

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. L. Cunningham, M.D.

Address 2458 Harford Rd Date signed 3/27/45

G27360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G27360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick B. Sutherland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Eleanor R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1877

8. AGE: Years	Months	Days	If less than one day
67	10	17	hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Frederick B. Sutherland
13. Birthplace N.Y.

MOTHER 14. Maiden Name Elizabeth Bush
15. Birthplace N.Y.

16 (a) Informant Mrs. F. C. Frenholm
(b) Address 212 Ridgewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location Balto

18 (a) Funeral director Wm Cox Inc
(b) Address 1217 St Paul St

MAR 29 1945 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Mch 29 1945 and that I last saw h[illegible] alive on Mch 27 1945.

Immediate cause of death	Duration
Carcinoma of intestines	2½ yrs
Due to	
Due to	
Other Conditions No other.	

(Include pregnancy within 3 months of death)

Date of operation 2½ yrs ago
Major findings of operation: Carcinoma ileocecal area of bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Baumann M.D.
Address 2200 Garrison Blvd Date signed 3/29/45

X

G27361

CWK-74958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G27361

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 9d 0h
(e) Length of stay in Baltimore (yrs., mos., or days) 77 Yrs. 9 mos. 15 ds. or 88 Yrs. 9 mos. 15 ds.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Alisa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Woodward,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-1856 Or 1867

8. AGE:	Years	Months	Days	If less than one day
	88	9	15	or ..... hr. ..... min.
	77	9	15	

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H. Woodward
13. Birthplace ?

MOTHER
14. Maiden Name Octavia A Ready
15. Birthplace Md.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 1437 Harford Rd.

MAR 29 1945
(Date rec'd by registrar)

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1945, to March 26 1945, and that I last saw h. alive on Mch. 26 1945

Immediate cause of death Broncho pneumonia — Duration 1 month

Due to

Due to

Other Conditions Gen. Arteriosclerosis Hard Pulse Pressure — 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.

Address Baltimore City Hospitals Date signed 3-28-45

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27362

JL - 86830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27362 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 0 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Alvaredo Square
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian O. Nieberlein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1917

8. AGE: Years	Months	Days	If less than one day
27	3	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business

FATHER
12. Name Henry F. C. Nieberlein
13. Birthplace Germany

MOTHER
14. Maiden Name Louise A. Popp
15. Birthplace Balto, Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5306 Harford Road

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

APR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1945, at 11,20 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7, 1944 to Mar. 27 1945 and that I last saw her alive on March 27, 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 yrs.
Antecedent	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dalton M. D.
Address Balto City Hosp Date signed 3/27/45

G27363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G27363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Lake Montebello Drive
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 9d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Lake Montebello Dr.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME William Alva Davis

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No. 212-12-9192

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Maria H. K. Wetherill
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 9-24-74

8. AGE: Years	Months	Days	If less than one day
70	6	4	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business —

FATHER
12. Name Roswell D. Davis
13. Birthplace Gilmanton, N. H.

MOTHER
14. Maiden Name Cassandra Dorney
15. Birthplace Mathews Co. Va.

16 (a) Informant Wm A. Davis Jr.
(b) Address Glyndon Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore city

18 (a) Funeral director J. F. Elliott Sons
(b) Address Reisterstown Md.

19 (a) ..... (b) Huntingtown Williamsport Md
(Date rec'd by registrar)

MAR 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to March 1945, and that I last saw him alive on 3-27 1945

Immediate cause of death	Duration
Carcinoma of the stomach	18 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1944
Major findings of operation: Carcinoma of the stomach & metastasis
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature O. Wm. Moore M. D.
Address 3105 Belair Rd Date signed 3-29-45

X

A CAUSE MUST BE ENTERED ON LINE (a). Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G27364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 35
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Riverside Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Pompa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Michael Pompa
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) 6-15-79

8. AGE: Years	Months	Days	If less than one day
65	9	14	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Michael Fish
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Medical
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorsuch Mill Road
18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. City
19 (a) (Date) (Registrar) Huntington for Williams

MAR 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 6:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1945 to March 28 1945 and that I last saw h-- alive on March 28 1945

Immediate cause of death	Duration
Circulatory failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions A.V. Block, B.B. Block, Cerebral embolus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert C. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 3/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G27365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27365 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town 603 Fairview Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore 29 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ida E. Klemm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Mr. J. J. Klemm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 - 1879

8. AGE: Years	Months	Days	If less than one day
65	8	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ? Ellrich
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Ida Klemm
(b) Address 500 North Pt. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Blvd.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Balto

19 (a) (Date received by registrar) (b) William H. Hemington Registrar

MAR 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945, at 10:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945 to 3/26 1945; and that I last saw h[illegible] alive on 3/26 19 45

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address St Joseph's Hosp Date signed 3/29/45

X

G27366 G27366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1463 Ramsdell St~~
(c) Hospital or institution: 1463 Ramsdell St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1463 Ramsdell St
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA DOEGEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F M | 5. Color or race W | 6. ~~(a)~~ Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Chas

6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Nov 5 1870

8. AGE: Years 74 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Not Known

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Chas Doegen
(b) Address 1463 Ramsdell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Rd,

18 (a) Funeral director Geo Lehnbach
(b) Address 525 N. Pine Church St

MAR 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/45 19 ; at 1015 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 45, Mar 27 1945, and that I last saw ~~her~~ alive on Mar 27 19 45

Immediate cause of death* Uremia — Duration 3 days
Due to Nephritis — 2 wks.
Due to Endocarditis — 6 mo.
Other Conditions Edema of Lungs, Gall Bladder disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lyman Poore, M.D.
Address 2702 W North Ave. Date signed 3-28-45

Hunting for Williamsport Md
Superior Records

G27367 G27367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Brunswick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9th Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Emma M Carey

3 (b) If veteran, name war —

3 (c) Social Security Account No. don't know

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Raymond L Carey

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct 22 1892

8. AGE: Years 53 | Months 5 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Forrest
13. Birthplace Maryland

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Raymond L. Carey
(b) Address Brunswick Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 1 1945 (month) (day) (year)

(c) Cemetery or crematory Park Heights
Location Brunswick Md

18 (a) Funeral director C. H. Zeile & Bro
(b) Address Brunswick Md

19 (a) ___ (Date rec'd by registrar) (b) ___ Registrar

MAR 30 1945 Huntington Hillsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/45 19 ..., at 3.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29/45 to 3/30/45 and that I last saw h[illegible] alive on 3/30/45

Immediate cause of death Decompensation

Due to Hypertension

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature T. D. Gascoway
Address So. Balto. Gen. Hospital Signed 4/4/45

95c

G27368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 | B

G27368 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St Mary's Co.
(c) City or town Ridge.
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME George Greene.

3 (b) If veteran, name war | 3 (c) Social Security Account

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Emma Greene

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-9-75

8. AGE: Years 69 | Months 11 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name William Greene.
13. Birthplace Va.

MOTHER 14. Maiden Name Annie Pumphries
15. Birthplace Md.

16 (a) Informant..... JOHNS HOPKINS HOSPITAL
(b) Address.....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)

(c) Cemetery or crematory Trinity
Location St Marys City Md

18 (a) Funeral director W. C. Hattersley & Sons
(b) Address Leonardtown Md
Huntington Williamsport Md

19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3.29. 1945, at 5.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3.18 1945 to 3.29 1945, and that I last saw h. alive on 3-29 1945.

Immediate cause of death: Cerebral Vascular accident — Duration .....
Due to: Hypertensive Cardiovascular disease
Due to:
Other Conditions: Carcinoma of Prostate

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Gordon McCoy
Address Box 175 Jo Hosp. Date signed 3-31-45

VS 150

93D.

AB60733 G27369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27369 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs- 4mos- 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Rosemont 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000a alabama Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wallace Overton

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Separated

6 (b) Name of husband or wife Eva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- ?-1860

8. AGE: Years 84 | Months 6 | Days ? | If less than one day ....hr. ....min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Samuel Overton
13. Birthplace Conn.

MOTHER 14. Maiden Name Drucilla LaYonnadie
15. Birthplace Conn.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAR 30 1945

19 (a) ....(Date rec'd by registrar) (b) ....

Huntington Williams M.D.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28- 1945, at 11:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1940 to 3-28- 1945, and that I last saw h. in alive on 3-28- 1945.

	Duration
Immediate cause of death: Multiple pulmonary emboli	1 week?
Due to: Mural thrombi	?
Due to:	
Other Conditions: Chronic Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 3-29-45

G27370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G27370

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn
(If outside city limits, write RURAL and give town)
(d) Street No. 6 Baltimore Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Kramer

3 (b) If veteran, name war: N

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband George Kramer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14th 1920

8. AGE: Years	Months	Days	If less than one day
24	3	14	hr. min.

9. Birthplace Benfield Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Max Back
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant George Kramer
(b) Address 6 Balto Court, Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 30 1945 (Date rec'd by registrar) (b) Registrar

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1945 to 3-28-1945 and that I last saw h[illegible] alive on 3-28-1945.

Immediate cause of death: Cachexia — Duration

Due to: Carcinoma of Cervix

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Carcinoma of cervix

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Schick M. D.

Address 1213 LIGHT ST Date signed 3-29-45

Hunting for Williams, Mrs

G27371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

G27371 Registered No. (or a)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6007 Park Nghts Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6007 Park Nghts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard E. Wasick

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sylvia D. Wasick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 13th 1909

8. AGE: Years 35 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace N. D.
(Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business U. S. War Dept.

FATHER
12. Name Stanley Wasick
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Alfred H. Denninger
(b) Address 6007 Park Nghts Ave

17 (a) Burial (b) Date thereof 3/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29th 1945, at 2:30 P.M

21. I certify that death occurred on the date above stated: that I attended deceased from 3/23 1945 to 3/29 1945, and that I last saw h/m. alive on 3/29 1945

Immediate cause of death Brain tumor — Duration about 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Malignant Brain tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Wilson

Address 5724 Park Heights Ave Date signed 3/29/45

VS 150

Huntington-Williams

X Wilson

G27372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27372 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 S. Willard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Willard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Rehmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine M. nee Breitenother

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1890

8. AGE: Years 54 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business Balto. City

FATHER 12. Name Rehmann

13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Remme

15. Birthplace Germany

16 (a) Informant Mrs. Katherine Rehmann

(b) Address 6 S. Willard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location 3001 Edmondson Ave

18 (a) Funeral director Harry H. Loitz Co

(b) Address 44 Hamburg St

19 (a) (b)

(Filed by registrar) Registrar

3 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to March 27 1945, and that I last saw him alive on March 19 1945

Immediate cause of death	Duration
Coronary Thrombosis (recurrent)	5 minutes
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kenneth Zapp

Address 3101 W Belvidere Ave Date signed M. 4 D. 9 45

VS 150

G27373 G27373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 S. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore F. Bach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Wilkinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1869

8. AGE: Years 75 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Balthasar Bach
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Miller
15. Birthplace —

16 (a) Informant Mrs Julia Bach
(b) Address 318 S. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day), (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) Date received by registrar 3-30-1945 (b) Signature of registrar Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1945 to Mar 27 1945 and that I last saw h. alive on Mar 27 1945

Immediate cause of death: Myocarditis

Due to: Following Long Carcinoma of Bladder

Due to:

Other Conditions: Arteriosclerosis General.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 3 days / 9 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Kahn

Address 7027 W Read St Date signed 3-29-45

VS 180

G27374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G27374 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Thomas K. Barrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes C. Herbes
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1868

8. AGE: Years	Months	Days	If less than one day
About 77	---	--	---hr. ---min.

9. Birthplace Cork, Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Daniel Barrett
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannah Kenny
15. Birthplace Ireland

16 (a) Informant Agnes H. Barrett
(b) Address 2930 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 80[illegible] N. Calvert Street

19 (a) MAR 30 1945 (b) [illegible] Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/ 1945, at 5.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 28 1945, and that I last saw h[illegible] alive on March 28 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Week
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2923 St Paul St Date signed 3/29/45

G27375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83C

G27375
Registered No.

Please write the causes of death clearly and legibly. Physicians: please see that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hans Bellas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1902

8. AGE: Years	Months	Days	If less than one day
42	9	18	hr. min.

9. Birthplace Sumpter, S.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Morgan Bellas
13. Birthplace Sumpter, S.C.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Flaaglaer Flood
(b) Address 147 Hamilton street

17 (a) Burial (b) Date thereof April 2, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumpter, S.C.
Location

18 (a) Funeral director Joseph A. Lively
(b) Address 4000 Mount Street

19 (a) Harrington Williams M.D.
(Date received by Registrar) Registrar

MAR 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1945, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Encephalomalacia

Due to Generalized tuberculosis chronic

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gratz M.D.
Medical Examiner.
Date signed 3-28-45

X

G27376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27376 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hosp
(c) Hospital or institution: Redwood & Greene St's
(d) Length of stay in hospital or inst. (yrs., mos., or days): 10 days
(e) Length of stay in Baltimore (yrs., mos., or days): 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Anne Arundel
(c) City or town: Pasadena - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Elaine White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 21, 1925

8. AGE: Years: 19 | Months: 6 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Lakeshore, Md. (Town, county, and state)

10. Usual Occupation: School

11. Industry or business

FATHER 12. Name: David White (deceased)
13. Birthplace: Wisconsin

MOTHER 14. Maiden Name: Mildred Anderson
15. Birthplace: Frederick, Md.

16 (a) Informant: Mrs. Mildred White
(b) Address: North Shore Rd., Broadneck, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 45 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Glen Burnie

18 (a) Funeral director: John F. Dempf, Inc.
(b) Address: 715 Light St.

Filed 3-30 1945 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-27-45 19 , at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1945 to 3-27 1945 and that I last saw her alive on 3-27 1945

Immediate cause of death	Duration
Eclampsia, Acidosis, Toxemia	
Due to: Advanced Bilateral Pulmonary tuberculosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: Advanced Pulm Tbc - Bilat

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: D Gleason M. D.
Address: Univ Hosp Date signed 3-27 1945

VS 190

G27377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27377 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SOUTH BALTO GEN'L HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, ~~days~~) 12 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 WALL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha A. Tucker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife DATE OF BIRTH SEPT. 22 1880

6 (c) ~~If alive, give age~~ ~~Years~~

NAME OF HUSBAND ALFRED E. TUCKER

7. Birth date of deceased (~~mo.~~, day, yr.)

8. AGE: Years	Months	Days	If less than one day
64	6	7	____ hr. ____ min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name MATHEW. J HILL
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name REBECRA. FITHION
15. Birthplace BALTO MD

16 (a) Informant ALFRED. E. TUCKER
(b) Address 1227 WALL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN CEM
Location GLEN BURNIE MD

18 (a) Funeral director Bernard C Harker
(b) Address 121 E West St

19 (a) ~~MAR 30 1945~~ (b) ~~Huntington Williams~~ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/45 to 3/29/45 and that I last saw h~~er~~ alive on 3/29/45

Immediate cause of death Anoxia — Duration

Due to Cardiac Decompensation

Due to Hypertensive C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address So. Baltimore Gen'l Hosp. Date signed 4/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G27378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G27378 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL E. SINTON

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife J. Frank Sinton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William W. Smoot
13. Birthplace Va.

MOTHER
14. Maiden Name Clara R. Davis
15. Birthplace Baltimore

16 (a) Informant Mr. J. Frank Sinton
(b) Address 3016 Virginia Ave.

17 (a) Burial (b) Date thereof 3/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar Huntington Williams M.D. Registrar

MAR 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1945, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1. 1944 to Mar. 28 1945, and that I last saw h[illegible] alive on 3-27. 1945.

Immediate cause of death — Duration
Carcinoma of Rectum — 2 yrs
Due to
Due to Exhaustion
Other Conditions
(Include pregnancy within three months of death)
Date of operation In room
Major findings of operation: Carcinoma Rectum removed
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature 1st Lieut. C. Blake
Address Med. Arts Bldg. Date signed 3-29-45

X

G27379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G27379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 9W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Round Hill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella F. Payne (Ella Frances Payne)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John E. Payne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1869

8. AGE: Years	Months	Days	If less than one day
75	7	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business Wm.

FATHER
12. Name Wm. P. D. Sessions
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. White
15. Birthplace Balto., Md.

16 (a) Informant Mrs. John A. Payne
(b) Address 3429 Guilford Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) 1945 (b) Huntington Williams M.D.

VS 189 D 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-45 19 , at 8:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8-45 19 , to 3-29-45 19 , and that I last saw her alive on 3-28-45 19

Immediate cause of death	Duration
Coronary thrombosis	
Due to	
Due to	
Other Conditions Auricular fibrillation, Pulm. infarction	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: Cor. thrombosis, Pulm. infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Brady M. D.
Address Md. Gen. Hosp. Date signed 3-29-45

X

AB9 G27380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G27380 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James V. Deane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20- 1850

8. AGE: Years	Months	Days	If less than one day
94	10	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Deane
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Ford
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3 - 31 - 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Hickson
(b) 1945 916 Pennsylvania Ave
(Date rec'd by registrar) (Registrar) Huntington Williams M.D.

19 (a)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27- 1945, at 4.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12- 1945 to 3-27 1945, and that I last saw h[illegible] alive on 3-27- 1945

Immediate cause of death	Duration
Lobar pneumonia	7
Due to	
Due to	
Other Conditions Coronary sclerosis, Chronic Nephritis	2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E W [illegible] M. D.
Address Baltimore City Hospitals Date signed 3-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27381 / 104

Registered No. G27381

Please write plainly, with unfading ink. Every item of information should be carefully written. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Chambers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4.17.94

8. AGE: Years	Months	Days	If less than one day
50 51	11	10	hr. min.

9. Birthplace 4-17-94 Va (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name Jacob Chambers.
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Chambers
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. County Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3.27 1945, at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3.26 1945 to 3.27 1945, and that I last saw h[illegible] alive on 3-27 1945.

Immediate cause of death	Duration
Respiratory arrest	
Due to Lobar Pneumonia due to Pneumococcus	
Due to type XII	2 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital 3/27/45

VS 150

G27382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 578 Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephus Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — — 1884

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Josephus Fields

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Rosa Walker

(b) Address 1302 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (month) (day) (year)

(c) Cemetery or crematory Balto Nat Cemetery

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave Huntingtown Anne Arundel, Md.

19 (a) (Date rec'd by registrar) — — 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 8:22 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3/26 1945, to 3/26 1945, and that I last saw h. im alive on 3/26 1945.

Immediate cause of death	Duration
Cerebellar Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.

Address Provident Hospital Date signed 3/29/45

VS 150

G27383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27383
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 W. 37th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Oscar William Ball (Gertrude May Ball)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. O. W. Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/19/1892

8. AGE: Years	Months	Days	If less than one day
52	8	9	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Hartman Ament
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ann Morgan
15. Birthplace Maryland

16 (a) Informant Oscar William Ball
(b) Address 1005 W. 37th Street

17 (a) Burial (b) Date thereof March 31-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Hampden
Location Baltimore, Maryland

18 (a) Funeral director Durgin Funeral Home
(b) Address 3291 Falls Road

19 (a) Registered by registrar Huntington Williams, M.D.
MAR 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1945, at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945 to 3/28 1945 and that I last saw h[illegible] alive on 3/27 1945

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Amnesia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan M.D.
M. D.
Address Date signed

VS 190

G27384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 Somersett Lb.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Somersett St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Redmond.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Celestine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1903

8. AGE: Years 41 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Gloucester, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Walter Redmond.
13. Birthplace Gloucester, Va.

MOTHER
14. Maiden Name Maggie
15. Birthplace Gloucester, Va.

16 (a) Informant Celestine Redmond.
(b) Address 1131 Somersett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie B. Williams
(b) Address 322 N. Schroeder St.

MAR 30 1945 (Date received by Registrar) Katie B. Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/45 19 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6/45 19 to 3/24/45, and that I last saw h[illegible] alive on 3/24/45.

Immediate cause of death: Pneumonia
Due to: C
Due to: Bronchial Asthma
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work? (Specify type of place)
(e) Manner of injury

23. Signature [illegible] M. D.
Address 526 G. Caswell [illegible] 3/30/45

VS 150

G27385

G27385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 318 Washburn Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4

(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town Baltimore (25) Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 318 Washburn Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jacob Koehl

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-3609

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or ~~wife~~ Maria Koehl

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 27-1866

8. AGE: Years	Months	Days	If less than one day
78	- 4	- 1	hr. ..... min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business American Oil Co

FATHER
12. Name Charles Koehl
13. Birthplace Germany

MOTHER
14. Maiden Name Mrs M Reichel
15. Birthplace Germany

16 (a) Informant Maria Koehl

(b) Address 318 Washburn Ave

17 (a) Burial (b) Date thereof 3/31-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Gov. Ritchie Highway & Shilling-

18 (a) Funeral director Milton S. Koppenheffer

(b) Address 3914 S. Hanover St Curtis Bay P.O. Baltimore, Md.

MAR 30 1945
(Date rec'd by registrar)

Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th 1945, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1945 to March 28 1945, and that I last saw h— alive on 3/28/45

Immediate cause of death	Duration
Due to Chronic myocarditis	
Due to	
Other Conditions Arthritis Cerebral Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation? .....

of autopsy? .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? .....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature Samuel Rubin M. D.

Address 203 Balapen Ave Date signed .....

G27386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V1216

G27386 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Ave & Dukeland St.
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Lansing Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Laura Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William Edward
6 (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) Jan. 31, 1906
8. AGE: Years 38 | Months 1 | Days 29 | If less than one day ... hr. ... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At. Home
11. Industry or business

FATHER
12. Name William Dobbs
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lena Rausch
15. Birthplace Baltimore, Md.

16 (a) Informant Husband
(b) Address 1625 Lansing Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto. Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) APR 2 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1945 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945, to 3/29 1945, and that I last saw h[illegible] alive on 3/29 1945

Immediate cause of death: Coronary Thrombosis — Duration: 3 hours
Due to: Chronic Glomerulo Nephritis — ? years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Taylor M.D.
Address 1126 N Date signed 3/29/45

G27387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G27387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 N Spring St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married (Spouse living)

6 (b) Name of husband or wife: Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1902

8. AGE: Years 42 | Months 10 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Walter Logan
13. Birthplace Va.

MOTHER
14. Maiden Name Ellen Brown
15. Birthplace Va.

16 (a) Informant Walter Logan
(b) Address 1231 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County Md.

18 (a) Funeral director Wm. Robert H. Elliott
(b) Address 1297 N. Caroline St.

19 (a) ... (Retained by registrar) (b) Huntington Willoughby M.D.

MAR 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 45 to 3/28 1945
and that I last saw him alive on 3/28 1945

Immediate cause of death: Bronchopneumonia
Due to: Epidermoid Carcinoma
Due to: Myxoma
Other Conditions:

Duration: 4 wks 8 wks

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave. Date signed 3/29/45

G27388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27388 Registered No. 1220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton + Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 2807 Keyworth Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. MARGARET A. HOPKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thomas B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1st 1872

8. AGE: Years 72 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace: Baltimore, Md (town, county, and state)

10. Usual Occupation: house work

11. Industry or business: at home

FATHER

12. Name: William F. Hardy

13. Birthplace: Baltimore Md

MOTHER

14. Maiden Name: Mary Burke

15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr Thomas B. Hopkins

(b) Address 2807 Keyworth Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location 4430 Belair Road

18 (a) Funeral director: John J Cowan & Son

(b) Address 901-03 Baltimore St.

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

MAR 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1945 to 3-29 1945 and that I last saw h alive on 19

	Duration
Immediate cause of death: Heart Failure	
Due to: Intestinal Obstruction	2 weeks
Due to: Diverticulitis with fecal fistula in	11 days
Other Conditions: mid abdomen and entero-vaginal fistula	6 Months

(Include pregnancy within 3 months of death)

Date of operation 2-8-1945

Major findings of operation: Diverticulitis enter vaginal Fistula + Terminal

of autopsy: Sister

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard W. Shier M. D.

Address St Agnes' Hospital Date signed 3/29/45

G27389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 27C

G27389 Registered No.

Please write the causes of death clearly and legibly. Respect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley A. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 10, 1944

8. AGE: Years	Months	Days	If less than one day
	9	19	hr. min.

9. Birthplace Baltimore. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis M. Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L. Dosch
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary L. Thompson
(b) Address 218 S. Carey St.

17 (a) Burial (b) Date thereof 3/31/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave.

18 (a) Funeral director John Howard Fox
(b) Address 90 03 Collins St.

(Date rec'd by registrar) MAR 30 1945 (b) Signature of registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1945 at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dysentery, unqualified.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer J. Means, M.D.
Medical Examiner.
Date signed March 29, 1945

G27390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G27390 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1270 Riverside Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1270 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Marsh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ada Marsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23 - 1874

8. AGE: Years	Months	Days	If less than one day
71	1	5	hr. min.

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Guard
11. Industry or business

FATHER 12. Name Walter W. Marsh
13. Birthplace Va.

MOTHER 14. Maiden Name Mary E. Walker
15. Birthplace Va

16 (a) Informant Ada E. Marsh
(b) Address 1270 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory W. Oliver
Location Baltimore Md.

18 (a) Funeral director Flynn & Phinney
(b) Address 14 N. Eutaw [illegible], M.D.

19 (a) (Date received by registrar) (b) Registrar

MAR 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28 1945 at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Mar 28 1945 and that I last saw h[illegible] alive on Mar 27 1945

Immediate cause of death	Duration
Cerebral thrombosis	20 days
Due to Cardio-vascular renal disease	4 yrs
Due to Arteriosclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. Hawthorne M. D.
Address 1241 Park St Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G27391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write Rural and give town)
(d) Street No. 4 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Nokes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Joseph Nokes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1886

8. AGE: Years 58 | Months 59 | Days 7 | If less than one day hr. min. 16

9. Birthplace Calvert Co. Md. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Burdison
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Harrison
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs Leona Hartlove
(b) Address 1223 Patapsco St

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1420 Light St

19 (a) 1930 1945 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 1.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28, 1943 to Mar. 28 1945 and that I last saw her alive on Mar. 27 1945

Immediate cause of death: Carcinoma of uterus and adnexia. (Inoperable) — Duration: 2 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 3/29/1945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27392 / 46E

G27392 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution Sinai Hospital 15-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1721 N. BENTALOU ST
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Katz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Joseph Hess

13. Birthplace Russia

MOTHER 14. Maiden Name Hannah

15. Birthplace Russia

16 (a) Informant Hosp. Records

(b) Address

17 (a) Burial (b) Date thereof 3-1-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wash. Rd.

Location Wash. Rd.

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St.

(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/1945, at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1945 to 3/29/1945 and that I last saw h-e alive on 3/29/1945

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Carcinoma 1 generalized, secondary to carcinoma	
Due to Of descending colon.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation August 44

Major findings of operation: Carcin. of desc. colon.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Stanley A. Stein M.D.

Address Sinai Hospital Date signed 3/29/45

G27393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27392 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Auchentoroly Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Solomon D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1875?

8. AGE: Years	Months	Days	If less than one day
69 70?	7	23	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs. Thomas Shanty
(b) Address ~~200~~ 116 Sudbrook Lane, Pikesville, Md.

17 (a) Burial (b) Date thereof 4-1-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Herrenj Rem
Location Philadelphia Baltimore Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1945, at 4:01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 29, 1945 to March 29 1945, and that I last saw her alive on March 29, 1945

Immediate cause of death Cerebral Embolus — Duration

Due to Arteriasclerotic Cardio-Vascular Disease, with Hypertension and

~~Due to~~ Auricular Fibrillation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. S. Bendit M.D.
Address Women's Hospital Date signed 3-29-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G27394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G27394
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Monument St. & Rutland Ave (If rural give location)
917 E. Madison
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HAWTOF

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-4-27
8. AGE: Years 17 Months 10 Days 24 If less than one day hr. min.
9. Birthplace Balti (Town, county, and state)
10. Usual Occupation School
11. Industry or business

MOTHER / FATHER
12. Name Joseph Hawtof
13. Birthplace Russia
14. Maiden Name Dora -
15. Birthplace Russia

16 (a) Informant Dora Hawtof
(b) Address 917 E. Madison St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Nursing Home
Location
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balti St
Huntington Williams, M.D. Registrar
MAR 3 1945 (Date Registered)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 28 1945, at 8:50 AM
21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1945, to 3/28/45 1945
and that I last saw him alive on 3/28 1945
Immediate cause of death cerebral hemorrhage
Due to meningitis
Due to ruptured appendix
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 3/19/45
Major findings of operation: pelvic abscess
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Irwin Cowland M. D.
Address Sinai Hosp Date signed 4/8/45

G27395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G27395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Cedardale road
(c) Hospital or institution:
15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Cedardale road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARGARET E. LUBBEHUSEN

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Leonard J. Lubbehusen
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1886

8. AGE: Years	Months	Days	If less than one day
59	2	2	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Lorenz Schoenlein
13. Birthplace Germany

MOTHER
14. Maiden Name Oldewurtel
15. Birthplace Germany

16 (a) Informant Leonard J. Lubbehusen
(b) Address 3400 Cedardale road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Cogan, Sons
(b) Address 119 W. [illegible] St.

19 MAR 31 1945 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 11 1945, to MARCH 27 1945, and that I last saw HER alive on MARCH 27, 1945

Immediate cause of death Coronary Thrombosis — Duration 2 days
Due to arteriosclerotic cardio vascular disease
Due to
Other Conditions Cholelithiasis
(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Sullivan M. D.
Address 2911 Garrison Blvd. Date signed 3-30-45

X

G27396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G27396

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Carroll
(c) City or town Westminster 5, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Jesse P. Carr
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) March 22, 1874

8. AGE: Years	Months	Days	If less than one day
71 70	—	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Granville Boone
13. Birthplace Maryland

MOTHER
14. Maiden Name Hester Webster
15. Birthplace Maryland

16 (a) Informant Harvey Carr
(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory Salem
Location Salem, Carroll Co Md

18 (a) Funeral director C. H. Wantz Sons
(b) Address Winfield Md

MAR 31 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to March 30 1945 and that I last saw h.e.r. alive on March 30 1945.

Immediate cause of death: Cardio-Respiratory Failure — Duration:
Due to Arteriosclerotic Heart Disease
Due to Generalized Arteriosclerosis
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. K. Sweeney
Address Union Mem. Hosp Date signed 5/30/45

VS 150

93D

G27397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Notre Dame of Maryland
(c) ~~Hospital~~ or institution: " N. Charles St., Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) Most of life
(e) Length of stay in Baltimore (yrs., mos., or days) Most of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Sister Mary Evaline – Agnes Mahon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 27, 1865

8. AGE: Years	Months	Days	If less than one day
79	9	2	...hr. ...min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Teaching

11. Industry or business —

FATHER
12. Name Darby Mahon
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Corliss
15. Birthplace Ireland

16 (a) Informant Sister Mary Ethelbert
(b) Address Notre Dame of Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31/45 (month) (day) (year)
(c) Cemetery or crematory Notre Dame
Location Govans

18 (a) Funeral director Geo. M. Fruit & Son
(b) Address 811 N. Wolfe St.

19 (a) MAR 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VE 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29, 1945, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/29 1945 and that I last saw h... alive on 3/29/1945.

Immediate cause of death	Duration
Acute cardiac dilatation	5 hrs
Due to Coronary disease	5 yrs
Due to Hypertension	7
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis L. Bagley M.D.

Address 6077 Harford Rd. Date signed M. 3 D. 30/45

G27398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

520a

Registered No. G27398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Mason (If outside city or town limits, write RURAL and give town)
(d) Street No. Rural Rt. #3 (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lola Thames

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-75

8. AGE: Years 69 | Months 7 | Days 15 | If less than one day .....hr. .....min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James C. Taylor
13. Birthplace Ga.

MOTHER
14. Maiden Name Nancy Grace
15. Birthplace Ga.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3 30 45 (month) (day) (year)
(c) Cemetery or crematory Mason Ga.
Location.....

18 (a) Funeral director Wm J Taylor & Son
(b) Address Work & Penna Ave

19 MAR 31 1945 (Date received) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION 85

20. DATE OF DEATH Mar 30 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1945 to Mar 30 1945 and that I last saw h[illegible] alive on Mar 30 1945

	Duration
Immediate cause of death: Cirrculatory failure	12 hrs
Due to: Pleural effusion + ascites from metastases	?
Due to: Carcinoma Kidney right	? 6 months
Other Conditions: Metastases to liver	

(Include pregnancy within 3 months of death)
Date of operation March 10 1945
Major findings of operation: Solid tumor involving right kidney + liver
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature David B. Cheek
Address Johns Hopkins Hospital Date signed 3/30/45 M. D.

G-7399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G-7399

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John St. 25
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) one mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 16
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Fieldcrest Court
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET PERTHANIA MARTIN

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	11	13 hr. 13 min.

9. Birthplace Deer Run, W. Virginia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adam Martin
13. Birthplace Franklin W Va

MOTHER
14. Maiden Name Eliza Reprode
15. Birthplace Hondonnine W Va

16 (a) Informant Mattie Eye
(b) Address Deer Run W Va

17 (a) Burial, cremation, or removal Interment (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Homedale
Location Deer Run W Va
18 (a) Funeral director Tillson & Son
(b) Address 1217 E Pratt St

MAR 31 1945 (Registrar) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945 at 1:17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1945 to March 30 1945, and that I last saw her alive on March 30 1945.

Immediate cause of death	Duration
Cholelithiasis & common Bile duct	
Due to Chronic cholecystitis + cholelithiasis	
Due to	
Other Conditions Arteriosclerotic cardio-vascular disease	

(Include pregnancy within 3 months of death)
Date of operation March 29, 1945
Major findings of operation: Gall stone in common bile duct
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Meuland Edwards M. D.
Address 2334 St. Paul St Date signed March 30 1945

VS 160

G27400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G27400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Pennsboro (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul H Pribble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Betty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-30-07

8. AGE: Years 37 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace W Va. (Town, County, and State)

10. Usual Occupation Mgr. Public Utility

11. Industry or business

FATHER
12. Name Ulysses Pribble
13. Birthplace U.S.

MOTHER
14. Maiden Name Ida Gregory
15. Birthplace W Va

16 (a) Informant Records. JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Masonic Cem.
Location Pennsboro, W. Va.

18 (a) Funeral director Wm. Funeral Home.
(b) Address 200 E Princess St

19 (a) MAR 31 1945 (Date rec'd by registrar) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 1945, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1945 to Mar 30 1945 and that I last saw him alive on Mar 30 1945

Immediate cause of death	Duration
Pulmonary Emboli	Immediate
Due to Femoral Thrombophlebitis	9 days
Due to	
Other Conditions Tumor of Right Thorax (Include pregnancy within 3 months of death)	one

Date of operation 4/10/45

Major findings of operation: Cholesteatoma, Rt. Pleura

of autopsy: Pulmonary Emboli

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr.
Address Johns Hopkins Hospital Date signed 3/30

G27401 Willie Mude Johnson G27401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 695 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 695 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Mude Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 238-24-1107

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Elnora

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1920

8. AGE: Years 24 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Sumpterton S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Lucius Johnson
13. Birthplace S. C.

MOTHER 14. Maiden Name Ella Bouress
15. Birthplace S. C.

16 (a) Informant Elnora Johnson
(b) Address 695 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Sumpter
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

MAR 31 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29, 1945 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 1945 to Mar 29 1945 and that I last saw h[illegible] alive on Mar 29 1945

Immediate cause of death: Acute hemorrhagic pancreatitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. F. Howell M.D.

Address 601 N. Carrollton Ave. Date signed 3/30/45

X

G27402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G27402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 St. Paul
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Staley Reddick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age 1910 years

7. Birth date of deceased (mo., day, yr.) Jan. 10. 1905

8. AGE: Years	Months	Days	If less than one day
35	2	20	hr. min.

9. Birthplace Walkersville Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Penn Railroad

FATHER
12. Name J. W. Reddick
13. Birthplace Walkersville Md.

MOTHER
14. Maiden Name Edith L. Staley
15. Birthplace Penna.

16 (a) Informant Mrs. Mary Reddick Rhoderick
(b) Address Frederick Md.

17 (a) Burial (b) Date thereof Apr. 3. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hanover Pa.

18 (a) Funeral director Rowell & Hartzler
(b) Address Woods for Huntington Williamsport, Md.

MAR 31 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1945 to 3/30 1945, and that I last saw him alive on 3/20 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral hemorrhage	3 hrs
Due to Hypertensive CVD	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy Byron Turner, Jr. M. D.
Address Mercy Hospital Date signed 3/30/45

VS 150

G27403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83N

Registered No. G27403

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 N. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Counts

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband John Counts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9th 1857

8. AGE: Years	Months	Days	If less than one day
88	1	20	hr. min.

9. Birthplace Balto., Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Simon Cosgrove
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigit Adams
15. Birthplace Ireland

16 (a) Informant Charlotte Counts
(b) Address 835 N. Fulton Ave

17 (a) Burial (b) Date thereof 4/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto., Md.

18 (a) Funeral director William Cook Inc
(b) Address St Paul & Preston, Balto

19 (a) MAR 31 1945 Huntington & Williams, Balto
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29th 1945 11:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945 to March 29 1945, and that I last saw her alive on 3/29 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	1 month
Due to	
Due to	
Other Conditions Hypertension	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Weller MD
Address 703 Wilkens Ave Date signed 3/29/45 (M. D.)

VS 150

27404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 27404

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Laurens St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Moore
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1918

8. AGE: Years 26 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John H. Moore
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ollie Bean
15. Birthplace Va.

16 (a) Informant Ollie Moore
(b) Address 1119 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-1945 (month) (day) (year)
(c) Cemetery or crematory Lancaster Co. Va.
Location

18 (a) Funeral director Wm. Chas. A. Holland
(b) Address 1631 Druid Hill Ave.

MAR 31 1945 Huntington Williams
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to Mar 28 1945, and that I last saw him alive on Mar. 28 1945.

Immediate cause of death Cardiac failure — Duration

Due to Rheumatic heart disease

Due to

Other Conditions Pneumonia, lobar, bilateral.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Rheumatic CVD + lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R Bayarmont M.D. M. D.
Address University Hosp. Date signed 3/29/45

VS 150

95.B

D27405. ✓ D27405.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Ethland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Ethland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Magdalena Burk

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1889

8. AGE: Years 55 | Months 7 | Days 11 | If less than one day: hr. min.

9. Birthplace Sweet Air Balto Co, Md
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Hutzler Bros Co

FATHER
12. Name Andrew Burk
13. Birthplace Carroll Dale Pa.

MOTHER
14. Maiden Name Katherine M. Traffo
15. Birthplace Blenheim Balto Co. Md

16 (a) Informant Mrs Marvine K. Bell
(b) Address 4404 Ethland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1945 (month) (day) (year)

(c) Cemetery or crematory St John Lutheran Cem
Location Blenheim, Md.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) APR 2 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th, 1945, at 8a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945, to March 30 1945, and that I last saw h[er] alive on March 27 1945

Immediate cause of death	Duration
Myocarditis	1 mo.
Due to Advanced arterio-sclerosis	?
Due to	
Other Conditions Hypertension	about 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S. Nesbitt M. D.

Address 2220 Harrison Blvd Date signed March 31/45

X

G27406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G27406

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6406 Old Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6406 Old Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Charles Street
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Sarah C. Street
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15-1872

8. AGE: Years	Months	Days	If less than one day
73	-	13	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name George Street
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Joseph C. Street
(b) Address 6406 Old Harford
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5805 Harford Rd.
MAR 31 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944 to March 28 1945 and that I last saw h[im] alive on March 23 1945

Immediate cause of death Carcinoma of Prostate Gland — Duration 6 mos.
Due to
Due to
Other Conditions Carcinoma of Pelvic Lymph (Metastatic) — 1 mo.
(Include pregnancy within 3 months of death)
Date of operation 11/15/44
Major findings of operation: (above)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Francis L. Bayli M.D.
Address 6077 Harford Rd Date signed 3/30/45

VS 150

G-7407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G-7407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Louise Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Bentley Tate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Tate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1895

8. AGE: Years	Months	Days	If less than one day
49	3	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business

FATHER
12. Name George H. Tate
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Jane Prince
15. Birthplace Virginia

16 (a) Informant Mrs. Mary Tate
(b) Address 3107 Louise Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAR 31 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 3/28 1945 and that I last saw h[illegible] alive on 3/28 1945

Immediate cause of death	Duration
Acute Coronary Occlusion	app 1 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? (Specify type of place)
(e) Means of injury

23. Signature W. J. Dennis M.D.
Address Med. Mem. Hosp Date signed 3/30/45 M. D.

VS. 150

S- J. B. Davis - Howard J. Warren M. D. x Dr. Dunnell

G27408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G27408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Lexington St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Pete Young

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: M

5. Color or race: Gipsy

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosie Young

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Mar 15, 1889

8. AGE: Years 56 | Months 0 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Oklahoma City (Town, county, and state)

10. Usual Occupation Copper Smith

11. Industry or business

FATHER
12. Name Tiko Youko
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Rosie Young
(b) Address Buffalo N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Wm. H. Wm. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) MAR 31 1945 (Date received by registrar) Handling for Williamsburg, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1945, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/30/45

Funeral notice to be given, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27409

J0 #2125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/3B

G27409 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write th... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 S. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Makowiecki or Frank Makowiccki

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-9073

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1893

8. AGE: Years	Months	Days	If less than one day
51	7	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business Pants contractor

FATHER
12. Name Vincent
13. Birthplace Germany

MOTHER
14. Maiden Name Unable to obtain information
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S Ann street

(c) Date received by registrar MAR 31 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 8:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14, 1945, to Mar. 30, 1945, and that I last saw him alive on Mar. 30, 1945.

Immediate cause of death — Duration

Pulmonary tuberculosis (7)

Due to Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Levin M. D.

Address Balt. City Hosp. Balto, Md. Date signed 3/30/45

G27410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53 ✓

Registered No. G27410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 Garrett Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Garrett Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Krause

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	M

6 (b) Name of husband or wife Mrs. Palmyre W. Krause
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 15, 1871

8. AGE: Years	Months	Days	If less than one day
73	9	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Tobacco broker (retired)
11. Industry or business Tobacco

FATHER
12. Name John Krause
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Sohpia Dorothea Amelia Seigman
15. Birthplace Germany

16 (a) Informant Mrs. Palmyre W. Krause
(b) Address 2316 Garrett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto. Md.

18 (a) Funeral director HENRY SANDER & SONS
(b) Address INCORPORATED

19 (a) Filed (Registrar) MAR 31 1945 (b) Registered Martha Lane Brinsfield
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1945, at 10.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24- 1945, to Mar 29 1945 and that I last saw him alive on 3-29- 1945.

Immediate cause of death	Duration
Cancer of face	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 3-30-45

X

3 G27411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G27411 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINIA HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 364 S Bond Lt. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Bond

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: BLANCHE BOND
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 18 1882

8. AGE: Years 62 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation BREWER
11. Industry or business FREE STATE BREWERY

FATHER
12. Name SAMUEL BOND
13. Birthplace GERMANY

MOTHER
14. Maiden Name ? ERHARDT
15. Birthplace GERMANY

16 (a) Informant WILLIAM BOND (SON)
(b) Address 3700 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 3/45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE.

18 (a) Funeral director Lilly & Zeller
(b) Address 403 S. WOLFE ST.

19 (a) Huntington Williams Mort (Registrar)

MAR 31 1945
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 6:14 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1945 to 3/30 1945 and that I last saw him alive on 3/30 1945

Immediate cause of death: Right sided ht. failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cor. pulmonale, Emphysema, RCVD

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Faulkner M.D.

Address Sinai Hosp. Date signed 3/30/45

X

G27412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G27412

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Spangler Lane (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean Goshen (GOSHEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1945

8. AGE: Years | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Leominster Mass (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Goshen
13. Birthplace Penna

MOTHER
14. Maiden Name Florence Cavanaugh
15. Birthplace Leominster Mass

16 (a) Informant parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory St Augustine
Location St Augustine Penna

18 (a) Funeral director Clarence F Kellman
(b) Address 1639 n Broadway

19 (a) (Date received by registrar) (b) Registrar

MAR 31 1945 Burlington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Disease	1
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kay

Address 1 H H Date signed 3/31/45

X

G27413 HEALTH DEPARTMENT—CITY OF BALTIMORE G27413

CERTIFICATE OF DEATH 108

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 McElderry St., Ward)

Length of residence in city or town where death occurred 3 yr. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Walter Richardson

If U. S. Veteran specify WAR

(a) Residence: No. 1414 McElderry St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	W

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Louise Richardson

6. DATE OF BIRTH (month, day, year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38 1907	March	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Riveter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month, date, year) 3/26/45 | 11. Total time (years) spent in this occupation 2 wks

12. BIRTHPLACE (city or town) (State or country) Oxford N. C.

FATHER

13. NAME Ronnie Richardson

14. BIRTHPLACE (city or town) (State or country) Wendell N. C.

MOTHER

15. MAIDEN NAME Rosetta Hall

16. BIRTHPLACE (city or town) (State or country) Apex N. C.

17. INFORMANT Leonie Napier

(Address) 1716 Presbury St

18. BURIAL, CREMATION, OR REMOVAL

Place Raleigh, N. C. Date Mar 31, 1945

19. UNDERTAKER Mrs Kitty R. Williams

(Address) 322 N. Schenck St

20. MAR 31 1945 (Signature) for Williams Undertaker.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3-29 1945

22. I HEREBY CERTIFY, That I attended deceased from 3-27 1945 to 3-27 1945

I last saw him alive on 3-27 1945. Death is said to have occurred on the date stated above, at 7:40 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	3 days
Other contributory causes of importance: Exposure to Cold	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Visual Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? No Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, how?

(Signed) R. H. Walters M. D.

(Address) 1443 Hager St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

V8 8

G27414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G27414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3031 Remington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Remington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie M. Keiser.

3 (b) If veteran, name of war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Howard B. Keiser.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1875

8. AGE: Years	Months	Days	If less than one day
70	2	-	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Smallwood
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary A. Hinton
15. Birthplace Maryland.

16 (a) Informant Nellie F. Kearney.
(b) Address 3031 Remington Ave

17 (a) Burial (b) Date thereof April 2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Elmore & Monsau
(b) Address 3615-17 Elmhurst.

19 MAR 31 1945 (b) Huntingtown, Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1945 at 11.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/ 1944 to 3/29 1945
and that I last saw h[illegible] alive on 3/27 1945

Immediate cause of death Carcinoma of Liver
Primary
Due to
Due to
Other Conditions Arteriosclerosis,
(Include pregnancy within 3 months of death)
Date of operation 12/29/44
Major findings of operation:
Carcinoma of Liver and
of autopsy: Duct

Duration
6 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. R. Hall M. D.
Address 2020 E. Clark Date signed 3/31/45

VS 150

G27415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27415 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Forge Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Samual William Graham.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Evie Myrtle

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 22, 1885

8. AGE: Years	Months	Days	If less than one day
59	-	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Hopkins University

FATHER 12. Name Mr. Allen Graham

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret ?

15. Birthplace Maryland

16 (a) Informant Elsie M. Graham.

(b) Address 1409 Forge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Ehrenwald & Sonnen

(b) Address 3615-17 Chestnut Ave.

19 (a) (Date received by Registrar) MAR 31 1945 (b) Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1945 to March 28 1945; and that I last saw h. alive on March 27 1945

Immediate cause of death	Duration
Cardio - Resp. Failure	
Due to Arterio - Sclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D.

Address U.M.H. Date signed

G27416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G27416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 St. Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME C. Morgan Marshall (Charles Morgan Marshall)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Mrs. C. Morgan Marshall (wife)

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 4-14-81

8. AGE: Years 63 | Months 11 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Walter Art Gallery Adm.

11. Industry or business

FATHER
12. Name William A. Marshall
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Dilworth
15. Birthplace Virginia

16 (a) Informant Hospital chart
(b) Address 33 Calvert.

17 (a) entombment (Burial, cremation, or removal) (b) Date thereof April 2-45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart & Marullo.
(b) Address 1084 N. Howard St.

19 (a) (Date received) MAR 31 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1945, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1945, to 3-30 1945 and that I last saw him alive on 3-30 1945

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Uremia

Due to: Arteriosclerotic heart disease

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Alfred Hutchinson M. D.
Address 208 E 34th St Date signed 3-31-45

G27417 ✓ G27417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 W Royal
(c) Hospital or institution: de Home 1424
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 W Royal
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Kenly Murphy

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John F. Murphy

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June-10-1855

8. AGE: Years 89 | Months 9 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Harford Co. Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Richard Kenly
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Elizabeth Cain
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs Elizabeth M. Emory (daughter)
(b) Address 3104 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-2-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stewart & Co.
(b) Address 108 W. North Ave.

19 (a) ____ (b) ____
(Date received by registrar) Registrar

MAR 31 1945

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to March 29 1945 and that I last saw h-r alive on March 28th 1945

Immediate cause of death: Carcinoma of the stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas White M. D.

Address 3005 St Paul St., Date signed 3-30-45.

0 X

G27418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G27418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Park Ave (If rural, give location)
(e) Citizen of foreign country? China (Yes or No)
If yes, name country

3 (a) FULL NAME Hay Mee (HoyMEE)

3 (b) If veteran, name war NONE
3 (c) Social Security Account No. NONE

4. Sex Male | 5. Color or race Chinese | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) abt 1873

8. AGE: Years abt 73 | Months — | Days — | If less than one day hr. min.

9. Birthplace China (Town, county and state)

10. Usual Occupation Retired Laundryman
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Lee Wah
(b) Address 312 Park Ave, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Woodlawn Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) (Date received by registrar) MAR 31 1945 (b) Huntington Matthews, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/45 19 , at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6/ 19 45 to 3/8 19 45, and that I last saw h.m alive on 3/8 19 45.

Immediate cause of death Respiratory Failure — Duration
Due to Cerebral Vascular Accident
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: Alone
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Percy Fotterman M. D.
Address Mondawmin Hgts Date signed 3/29/45

X

G27419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1200

Registered No. G27419

Please write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 N. Kenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda Mueller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Adam G. Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1893

8. AGE: Years	Months	Days	If less than one day
52	1	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Peter Reisz
13. Birthplace Germany

MOTHER
14. Maiden Name Gena Webster
15. Birthplace Balto. Md.

16 (a) Informant Adam G. Mueller
(b) Address 502 N. Kenwood Ave

17 (a) Burial (b) Date thereof April 3 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director Philip Herwig Jones
(b) Address 2024 Orleans St.

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar)

MAR 31 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1945; at P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Ulcerative Enterocolitis and Enteritis

Due to Necrotic

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-31-45

G27420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G27420 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2532 W. LOMBARD ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 W. LOMBARD ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] BENJAMIN PARKS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Ellen Parks
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 10, 1859

8. AGE: Years	Months	Days	If less than one day
86	9	21	hr. min.

9. Birthplace Hoffmansville Chester Co. Pa. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Jackenje Parks.
13. Birthplace [redacted]

MOTHER 14. Maiden Name Nellie Parks.
15. Birthplace —

16 (a) Informant Dora Hoffland
(b) Address 2532 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2 '45 (month) (day) (year)
(c) Cemetery or crematory CAMBRIDGE CEMETERY
Location CAMBRIDGE MD.

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 EUTAW PLACE.

19 (a) [redacted] (b) [redacted] Huntington Williams
(Date received by Registrar) Registrar

MAR 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 31, 1945, 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1945 to Mar 30 1945 and that I last saw h[redacted] alive on Mar 30 1945.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to	
Due to Cardio Pulmonary disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Henry Clausman M. D.
Address 753 W. FAYETTE ST. Date signed

X

G27421 ✓ G27421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Webster St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leep, Ethel M

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day: hr. min.

9. Birthplace Clarksburg W. Va. (Town, county, and State)
10. Usual Occupation Home Work
11. Industry or business

FATHER
12. Name George Ritter
13. Birthplace W. Va.

MOTHER
14. Maiden Name Alma Davidson
15. Birthplace W. Va.

16 (a) Informant Hospt Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-31-45 (month) (day) (year)
(c) Cemetery or crematory Clarksburg
Location W. Va.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

19 (a) MAR 31 1945 (Filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1945, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1945 to 3-30 1945, and that I last saw HE alive on 3-30 1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Pleural + Hemorrhagic Pericardial Effusion	
Due to Hodgkin's Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy { Hydrothorax Hemorrhagic Pericard. Eff. Hodgkin's - Mediastinal }

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jerome R. Darkus M. D.
Address Sinai Hospital Date signed 3/31/45

G27422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a ✓ G27422 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 Ariguith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 5-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Arguith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George. A. Allen. M. D.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Juanita Allen (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1899

8. AGE: Years 45 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md (town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name William F. Allen
13. Birthplace Md

MOTHER
14. Maiden Name Emily Fidgeway
15. Birthplace Md

16 (a) Informant Juanita Allen Wife
(b) Address 121 Arguith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/45 (Day, month, year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Robert L. Gruber
(b) Address 801 E. Carlisle St

19 (a) (Date received by registrar) (b) Registrar

MAR 31 1945

Hunting for Information

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/45, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945 to 3/27 1945; and that I last saw h— alive on 3/26 1945

Immediate cause of death Cerebral apoplexy — Duration 1 Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Harris M. D.
Address 1407 N Caroline St Date signed 3/31/45

Bernard Harris 3/31/45

G27423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

✓ G27423 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore city (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Stricker St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Morrell Washington Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years.

7. Birth date of deceased (mo., day, yr.) Jan 3, 1924
8. AGE: Years 21 | Months 3 | Days 26 | If less than one day ....hr. ....min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation chauffeur
11. Industry or business none

FATHER
12. Name Morrell Washington Sr.
13. Birthplace Lancaster co. Va

MOTHER
14. Maiden Name Hallorah Reid
15. Birthplace Middlesex co. Va

16 (a) Informant Alvenia Thomas
(b) Address 602 Collett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md
18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St.
19 (a) (Date received by registrar) MAR 31 1945 (b) Registrar Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1945, at 2:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1945, to 3-29-1945, and that I last saw him alive on 3-28-45

Immediate cause of death: Pulmonary T.B. — Duration: 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 3-31-45

X

H71313 G27424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife 1-26-25
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-25

8. AGE: Years	Months	Days	If less than one day
20	2	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Alban
13. Birthplace Va

MOTHER
14. Maiden Name Estelle Wilkins
15. Birthplace Va

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory Arlington cem.
Location Md

18 (a) Funeral director George H. Kelly
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by reg.) (b) Registrar

MAR 31 1945

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March 30 1945, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1945, to March 30 1945, and that I last saw h[illegible] alive on March 29 1945.

Immediate cause of death: Respiratory failure
Due to: Cardiac failure
Due to: Rheumatic heart disease mitral stenosis & insufficiency
Other Conditions: Aortic insufficiency
(Include pregnancy within 8 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William T. Dixon
Address Johns Hopkins Hospital 3/30/45

Inspector Williams, M.D.

X

G27425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G27425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Greenmnt Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A Byrnes

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dr. John B. Byrnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 22 187?

8. AGE: Years 72 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Home urfe

11. Industry or business

FATHER 12. Name Charley Gutberlet

13. Birthplace Germany

MOTHER 14. Maiden Name Margt Walter

15. Birthplace Germany

16 (a) Informant Dr Byrnes

(b) Address 1029 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 917 Greenmount Ave

MAR 31 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1929, to March 28 1945, and that I last saw her alive on March 29 1945.

Immediate cause of death	Duration
Chron. Diabetic Mellitus	25 yrs.
Due to Pernicious Anaemia	15 yrs.
Due to Chronic Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Ayd M. D.

Address 2005 E. Monument St Date signed 3/30/45

Dr Ayd - 2005 E. Monument St X

627426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 627426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cedar & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank K. Collette
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-9535

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1895

8. AGE: Years	Months	Days	If less than one day
50	1	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Douglas Aircraft Corp.

FATHER
12. Name William E. Collette
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine E. Burns
15. Birthplace Maryland

16 (a) Informant Mrs Cora Collette
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Black Rock
Location Butler Md.

18 (a) Funeral director Easton Long
(b) Address Ellicott City, Md.
(Signature of local registrar) Huntington Williams, M.D.

MAR 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 3/30 1945 and that I last saw h.e.r alive on 3/30 1945.

Immediate cause of death	Duration
Heart failure	
Due to Coronary Thrombosis	
Due to arteriosclerosis of coronary vessels	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Byron M.D.
Address St Agnes Hosp Date signed 3/30/45

G27427 ✓ G27427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL)
(d) Street No. 2201 Harford Av. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary A. Burkhouse

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
—	—	Female	White	Married

6 (b) Name of husband or wife Martin J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 7-1890

8. AGE: Years	Months	Days	If less than one day hr.	min.
54	8	22		

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name John. Haggerty
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Lemrey
15. Birthplace Pa.

16 (a) Informant Martin J. Burkhouse
(b) Address 2201 Harford Av. Rd.

17 (a) Burial (b) Date thereof 4/1/45
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Mason
(b) Address 800 E. Baltimore St.

19 (Signature of local registrar) MAR 31 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1945 at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1945 to 3/29 1945 and that I last saw h alive on 3/29 1945

Immediate cause of death Cholemia — Duration 2 hrs
Due to Hepatitis — 3 wks.
Due to Cause unknown
Other Conditions Chronic Cholecystitis & Cholelithiasis.
(Include pregnancy within 3 months of death)
Date of operation 3/14/45
Major findings of operation: Hepatitis chronic cholecystitis.
of autopsy: Hepatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Strickland, M. D.
Address Bon Secours Hosp Date signed 3/-9/45

VS 180

G27428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E 827429 Registered No. G27428

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 St. Barnabas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 St. Barnabas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (LEWIS) Louis Wilson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race A. C. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/80

8. AGE: Years 65 | Months | Days 4 | If less than one day hr. min.

9. Birthplace Danville Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Nannie Wilson
(b) Address 905 St. Barnabas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 2 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania

19 (a) 4-1-1945 (b) Huntington Williams Registrar
(Date received by registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1944 to 3/29 1945 and that I last saw him alive on 3/27 1945.

Immediate cause of death Myocarditis — Duration Indefinite

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Casey C. Johnson M. D.
Address 1802 Penna Ave Date signed 3/29/45

G27429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G27429 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. 956 Franklintown Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Clarke Lindsay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1913

8. AGE: Years 31 | Months 8 | Days 30 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Bandage Fabric

11. Industry or business

FATHER
12. Name Thomas Lindsay
13. Birthplace Pa.

MOTHER
14. Maiden Name Amanda Campbell
15. Birthplace W. Va.

16 (a) Informant Irma Lindsay
(b) Address 956 Franklintown Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Ridgelawn Cemetery
Location Pa.

18 (a) Funeral director Wm J. Lucas & Son
(b) Address Baltimore Maryland

19 (a) (Date rec'd by registrar) Municipal Building

APR 1 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1945 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1945 to Mar 3 1945
and that I last saw h. alive on Mar. 1945

Immediate cause of death: Pneumonia
Generalized septicemia
Due to Infection an Antibiotic.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Shaynor M. D.
Address Md. Gen'l Hosp. Date signed

G27430 ✗ ✓ G27430

G27430 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Woodlea Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Orange (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Calvin Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Alice Johnson
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	23	hr. min.

9. Birthplace Orange Va (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Georgia

MOTHER
14. Maiden Name Elizabeth Sullivan
15. Birthplace [illegible] Va

16 (a) Informant Mrs. Paul J. de Brand
(b) Address 4311 Woodlea Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Zoar Bap. Church Cem
Location Orange Co Va
18 (a) Funeral director Howard N. Blight, Jr
(b) Address 4914 Belair Rd

19 (a) 1945 (Filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1945 to 3/30 1945 and that I last saw h.wife. alive on 3/28 1945

Immediate cause of death Carcinoma Stomach — Duration 1 year.
Due to ✓
Due to ✓
Other Conditions ✓
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: ?
Carcinoma Cardiac end Stomach.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Harding
Address 4810 Belair Rd Date signed 3/31/45

VS 150

X

G27431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G27431 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4618 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Leavey

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-4124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Nee Horwitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Sales Manager

FATHER
12. Name Hyman Leavey
13. Birthplace Russia

MOTHER
14. Maiden Name Annie D. Williams
15. Birthplace Russia

16 (a) Informant Sarah Leavey
(b) Address 4618 Pimlico Road

17 (a) Burial (b) Date thereof April 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to March 29 1945 and that I last saw alive on March 29 1945.

Immediate cause of death	Duration
Acute Pulmonary Oedema	1 day
Due to Aortic Insufficiency	
Due to Mitral Coronary Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mullan & Lawman
Address 5013 Park Heights Blvd Date signed 3 [illegible] M.

VS 150

G27432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G27432

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2569 W Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2569 W Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine J Koenig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29 1886

8. AGE: Years 58 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Balt Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frederick D Wagner
13. Birthplace Md

MOTHER
14. Maiden Name Leona Ampreen
15. Birthplace Md

16 (a) Informant George J Koenig
(b) Address 2569 W Fairmount Ave

17 (a) Burial (b) Date thereof Apr 2 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director George G Farley
(b) Address Fulton & Fayette Sts

19 (a) 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1945 at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 3/29 1945 and that I last saw h.e alive on 3/29 1945

Immediate cause of death: Carcinoma of Brain secondary to Colon — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. G. Salzinski M. D.

Address 5212 Commonwealth Ave Date signed 3/31/45

VS 150

G27433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G27433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Pulaski St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E Jane Parker

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29 1856

8. AGE: Years 88 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Robert Sledge
13. Birthplace N. C

MOTHER 14. Maiden Name Nancy Flemming
15. Birthplace N C

16 (a) Informant Helen E Parker
(b) Address 533 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 1943 to March 29 1945, and that I last saw h.er alive on March 28 1945.

Immediate cause of death	Duration
Congestive Heart Failure	1 wk
Due to Arterio-sclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Mollenus M. D.
Address 3321 Fred. Ave Date signed 3-29-45

VS 150

G27434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G27434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Arthur H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1873

8. AGE: Years	Months	Days	If less than one day
72	1	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William G. Caulk
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Kirby
15. Birthplace Md.

16 (a) Informant Ella M. Spicer
(b) Address 811 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) APR 1 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1945, at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from D.O.A. 19 to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to Arteriosclerotic Heart disease	
Due to	
Other Conditions D.O.A.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Address Md. Gen'l Hospital Date signed 4/2/45

G27435 X ✓ G27435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balt
(c) City or town Balt Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Ventnor Terrace (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1874

8. AGE: Years 71 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Frank Young
13. Birthplace Maryland

MOTHER 14. Maiden Name Rose Fradenburger
15. Birthplace Maryland

16 (a) Informant Juanita Graff
(b) Address 102 Ventnor Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 5 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945, to March 31 1945, and that I last saw h. alive on March 31 1945.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Coronary Sclerosis

Due to:

Other Conditions: Removal Prostate Hypertrophy (Include pregnancy within 3 months of death)

Date of operation 3/30/45

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Glenn Hatch, M. D.
Address C. H. H. Date signed 3-31-45

X

G27436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G27436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4 7
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Linden ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glenn Jean King

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 28 45

8. AGE: Years — | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles V. King
13. Birthplace Md.

MOTHER
14. Maiden Name Blanche M. Miller
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Blanche M. King
(b) Address 1329 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 45 (month) (day) (year)

(c) Cemetery or crematory Balto. Cemetery
Location North ave & Gay sts

18 (a) Funeral director John Whitehead Howe
(b) Address 700 Eutaw Place

19 (a) (Date received by registrar) APR 1945 (b) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1945, to March 31 1945, and that I last saw her alive on March 31 1945.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad Gordon M. D.
Address 2201 W. North ave Date signed 3-31-45

X

G27437 ✓ G27437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd - Calvert
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 Home for Incurables (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME E. Allen Hays

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	16	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name Thomas R. Hays
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Wilson
15. Birthplace Maryland

16 (a) Informant Thomas A. Hays
(b) Address Elkridge, R.F.D., Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 1945 (month) (day) (year)
(c) Cemetery or crematory Rock Spring Cem
Location near Bel Air, Md.

18 (a) Funeral director John Armistead Sons
(b) Address 1900 Eutaw Place

19 (a) 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1945 at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28-45 19..., to 3-31- 1945, and that I last saw him alive on 3-31- 1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions Acute Cholecystitis Hemiplegia, left (Include pregnancy within 3 months of death)	

Date of operation 3-28-45

Major findings of operation: Acute Cholecystitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul S. Craig M. D.
Address Union Memorial Hospital Date signed 3-31-45

VS 150

G27438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27438 ✓ 42E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Tyson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Tyson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1898

8. AGE: Years 46 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name J. Morris

13. Birthplace Howard Co.

MOTHER 14. Maiden Name Estella Crawford

15. Birthplace Howard Co.

16 (a) Informant

(b) Address 916 Tyson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-45 (month) (day) (year)

(c) Cemetery or crematory Western Star

Location

18 (a) Funeral director Adolphus Halsted

(b) Address 918 David Hill Ave.

19 (a) APR 1 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12th. 45 Mar. 28th. 45. and that I last saw her alive on Mar. 27th. 45.

Immediate cause of death	Duration
Endocarditis	unknown
Due to Myocarditis	unknown
Due to -----	
Other Conditions Secondary Anemia	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. D. Morgan M.D.

Address 401 E. 25th. St. Date signed 3/31/45

X

G27439 ✓ G27439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 758 W. Fayette St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County V
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 758 W. Fayette St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Cornelia Jane Washby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 21, 1876

8. AGE: Years	Months	Days	If less than one day
69	7	9	..... hr. ..... min.

9. Birthplace Charlestown, W. Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name .....
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Davis
15. Birthplace W. Virginia

16 (a) Informant Joseph L. Washby
(b) Address 758 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory .....
Location Charlestown, W. Va.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) ..... (Date received by registrar) (b) Huntington Williams, M.D. Registrar

APR 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to March 30 1945 and that I last saw h alive on March 30 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature M A Wilson M. D.
Address 803 N Fremont Date signed .....

X

G27440 G27440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Every question must be answered. Do not abbreviate. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Dent

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife James H. Dent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	9	hr. min.

9. Birthplace Morgantown W. Va. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John A. Martin
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Powell
15. Birthplace Baltimore

16 (a) Informant Mrs. B. B. McGinnis
(b) Address 1417 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-45 (month) (day) (year)
(c) Cemetery or crematory
Location Morgantown W Va

18 (a) Funeral director Wendell E Humphreys
(b) Address 1241 N. Broadway.

19 (a) APR 1 1945 (Date rec'd by registrar) Hurston Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 19 45, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally, Medical Examiner.
Date signed 3/31/45.

G27441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1943

G27441 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Morgue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Charlotte
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Church St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Starr Lee Culp.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 28? Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-45 (month) (day) (year)

(c) Cemetery or crematory
Location Charlotte N.C.

18 (a) Funeral director R. Lee Cder
(b) Address 44 Hopkins Pl.

APR 1 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at 4/1 ? M.
(b) Where did injury occur? Jones Falls - Riv #6
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard Medeiros M.D.
Medical Examiner.
Date signed 9-31-45

VS 151

627442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

627442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Sharp Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Winter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MOSES HAYES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 24 | Months 23 | Days | If less than one day hr. min.

9. Birthplace Lee County S. C
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Priscilla
15. Birthplace Lee County S. C

16 (a) Informant J. M. Lyons
(b) Address Bishopville S. C

17 (a) Burial (b) Date thereof April 4, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mark
Location Lee County South Carolina

18 (a) Funeral director Joseph A. Lively
(b) Address 1021 Mount Street

19 (a) 1945 (b) Huntington Williams, Registrar
(Date filed by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1945 at 1 20 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wounds
of Chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-27-45 at M.
(b) Where did injury occur? 1014 Sharp Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 27 1945

X

G27443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G27443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4610 Garrison Blvd.
(c) Hospital or institution: 118
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4610 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CATHERINE ELIZABETH KNOOP

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Max V. Knoop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1862

8. AGE: Years 83 82 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Alt
15. Birthplace Germany

16 (a) Informant Mrs. J. E. Smith
(b) Address 4610 Garrison Blvd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 1 1945 (Date rec'd by Registrar) (b) Registrar Wilmer Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 7:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1945 to 3/30 1945, and that I last saw h[illegible] alive on 3/27 1945

Immediate cause of death	Duration
Carcinoma of intestine	6 mos.
Due to	
old age	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Harris M. D.
Address 3901 Garrison Blvd Date signed 3/31/45

VS 150

X

G27444 BALTIMORE CITY HEALTH DEPARTMENT G27444
CERTIFICATE OF DEATH 95c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Silver Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Silver Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SIG STARKEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva C. Starkey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1862

8. AGE: Years 82 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Blanchester, Ohio (Town, county, and state)

10. Usual Occupation Lawyer (retired)

11. Industry or business

FATHER
12. Name Isiah Starkey
13. Birthplace Blanchester, Ohio

MOTHER
14. Maiden Name Laura Ingersoll
15. Birthplace W. Va.

16 (a) Informant Mrs. DeRose McGreevy
(b) Address 2810 Silver Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) [illegible] Williams
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 4:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to March 1945, and that I last saw h[illegible] alive on 3/25 1945.

Immediate cause of death: Cardiac Asthma — Duration
Due to: Arteriosclerosis
Due to:
Other Conditions: Emphysema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 4310 Liberty Hts Date signed M. 3 D. 30/45

VS 150

G27445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G27445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2129 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE BARBARA HASLING

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Hasling
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 17, 1872
8. AGE: Years 73 72 | Months 0 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hohman
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Paul
15. Birthplace Balto.

16 (a) Informant Mr. Theodore Hasling
(b) Address 2129 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1945 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Mar 30 1945 and that I last saw her alive on Mar 30 1945

Immediate cause of death: Aortic Stenosis — Duration: 3 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson M. D.
Address 3055 N. North ave Date signed Mar. 30 45

VS 150

G27446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27446 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Powhatan Ave.
(c) Hospital or institution: 1548
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Powhatan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ALBERT KOLLMEYER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth M. Kollmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1867

8. AGE: Years 77 77 | Months 11 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Dry Goods Merchant

11. Industry or business Retired 30 yrs.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Robert L. Kollmeyer
(b) Address 5101 Leeds Ave. Balto. 27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 4.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 27 1945, to MARCH 29 1945, and that I last saw h/M alive on MAR 29 1945

Immediate cause of death: arteriosclerotic-cardio vascular disease — Duration: 8 years

Due to

Due to

Other Conditions: Bronchiectasis Purulent sinusitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Lieberman M. D.
Address 2911 Barrison Blvd Date signed 4-1-45

VS 150

X

G27447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27447 164E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Street
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (Or Country) Somerset
(c) City or town East Berlin
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. number 3
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME George N. Ruth

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Edna Holland
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan 12 1895

8. AGE: Years	Months	Days	If less than one day
50	2	19	hr. min.

9. Birthplace York Co. Pa.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Franklin Ruth
13. Birthplace York Co. Pa.

MOTHER
14. Maiden Name Jane Lambert
15. Birthplace York Co. Pa.

16 (a) Informant Mrs. Hessie Ruth
(b) Address Berlin Pa.

17 (a) Removal (b) Date thereof 4/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location East Berlin Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Due to Internal Injuries
Fractured Humerus
Other Conditions Avulsion: left Axilla
Head Injury
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 31 at 1 A. M.
(b) Where did injury occur? Union Memorial
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John E. Davis M.D.
Medical Examiner.
Date signed 3/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

OVER

G27448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1852 2nd Dist. Balto. Md.

Registered No. 132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4218 6th St
(c) Hospital or institution: Y
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. - 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4218 6th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lionelle H. Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. -259-10-8446

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Allene E. Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1911

8. AGE: Years 34 | Months - 2 | Days - 8 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Bethlehem Fairfield SSCo

FATHER
12. Name Jos T. A. Hall
13. Birthplace Georgia

MOTHER
14. Maiden Name Mary Grady
15. Birthplace Georgia

16 (a) Informant Geneva Witcher
(b) Address 4216 Hazel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Bowman Cemetery
Location Bowman Georgia

18 (a) Funeral director Mitton Schilling
(b) Address 3914 Hanover St (Balto 25)

19 (a) (b)
(Date received by registrar) Registrar

APR 1 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 19 , at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16 1945, to Mar. 30 1945, and that I last saw h. alive on Mar. 30, 1945.

Immediate cause of death	Duration
Uremia	Over
Due to Nephritis	week
Due to	
Other Conditions Pericarditis	

(Include pregnancy within 3 months of death)

Date of operation /

Major findings of operation: /

of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm G Winfield M. D.

Address 1921 Eutaw Pl. Date signed 3/31/45

X

AYARES

G27449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G27449 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3924 Fairview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME TINA B. AYARES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Corina Ayares

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hyman Baylin
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Lee Ayares
(b) Address 2403 Kenoot Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom Cem
Location Windsor Mill Road

18 (a) Funeral director Jos. Levin Inc
(b) Address 439 E. Balto. St

19 (a) (Date rec'd by registrar) Huntington Williams Registrar

VR 11545

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945, to 3/31 1945, and that I last saw h[illegible] alive on 3/31 1945

Immediate cause of death Cardiac Resp Failure — Duration

Due to Intestinal Obstruction

Due to Perforation - Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Simon M. D.

Address Sinai Hospital Date signed 3/31/45

X

G27450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27450 Registered No. 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balt. Dent'l. Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 S. Conkling st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Tompakar
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-1945

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leonard Tompakar
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Julia Keene
15. Birthplace Brooklyn, N.Y.

16 (a) Informant Joseph Keene
(b) Address 534 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-45 (month) (day) (year)
(c) Cemetery or crematory Wolfman Circle
Location Cohens Mt Carmel
18 (a) Funeral director Jack Keene Inc
(b) Address 1739 E. Balto St
19 (a) 1945 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31- 1945 at 5 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945 to 3/31 1945, and that I last saw h[illegible] alive on 3/30 1945.

Immediate cause of death	Probable intra-cranial injury.	Duration
Due to	Breech presentation and difficult extraction	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilfred K. Konigsberg M.D.
Address 1211 Eutaw Place Date signed 3/31/45

G27451 G27451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring & Belvedere
(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring & Belvedere
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonie Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Michael Levy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Ellis Rosenblatt
13. Birthplace Russia

MOTHER
14. Maiden Name Chia –
15. Birthplace Russia

16 (a) Informant Morris Rosenblatt
(b) Address 436 N. Bay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Balto St

19 (a) 1945 (Date rec'd by registrar) (b) Lington Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1944 to 4-1 1945 and that I last saw h[illegible] alive on 4-1 1945

Immediate cause of death: Carcinoma of small intestine — Duration
Due to: Chr. card. Vascular disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin
Address Levindale Date signed 4/1/45

X

G27452 O'Grady ✓ G27452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 Bartlett Ave (1st)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) **FULL NAME** Mrs Catherine E. O'Grady ✓

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F — 5. Color or race W — 6 (a) Single, married, widowed, or divorced. ~~W~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name William Farley

13. Birthplace Baltimore

MOTHER 14. Maiden Name Catherine Farley

15. Birthplace Ohio

16 (a) Informant Mrs E. O. Grady

(b) Address 635 Bartlett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery

Location —

18 (a) Funeral director Mary M. Wiedefeld

(b) Address 501 E. 22nd St

APR 3 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945 to March 29 1945 and that I last saw her alive on March 28 1945.

Immediate cause of death: Bilateral Fatal Lobar Pneumonia — Duration 24 hrs

Due to —

Due to Cerebral Hemorrhage — Duration of hrs -?

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Autopsy

Lobar pneumonia

of autopsy: Bilateral Fatal Lobar Pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. M. Bacon Jr M. D.

Address St Josephs Hospital Date signed 3-29-45

VS 180 Huntington Williams, M.D.

G27453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rockeland St. - Ranyner Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Hilman Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Mayer

3 (b) If veteran, name war: Spanish American War
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emily M. Mayer (nee Loeb)
6 (c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): Feb. 8 1870
8. AGE: Years 75 | Months 1 | Days 22 | If less than one day: hr. min.
9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Insurance
11. Industry or business: Insurance
FATHER 12. Name: Leopold Mayer
13. Birthplace: Germany
MOTHER 14. Maiden Name: Caroline Michel
15. Birthplace: Germany
16 (a) Informant: Mrs. Emily M. Mayer
(b) Address: 2523 Hilman Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4 (month) | 2 (day) | 45 (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md.
18 (a) Funeral director: Geo. Wilson & Son
Address: 2503 Edmondson Ave
19 (a) (b) (Date rec'd by registrar) APR 2 1945 Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945 to March 30 1945, and that I last saw him alive on March 30 1945.

Immediate cause of death: Ventricular tachycardia — Duration:
Due to: Coronary thrombosis with myocardial infarction
Due to: Arteriosclerotic H.D.
Other Conditions: Hemoptysis at Metastatic cancer unknown
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: A. Silberfeld
Address: West Bal. H.H. Date signed: 3 M.D. 1945

VS 150

G27454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G27454 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Cathedral Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Over 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Hayes Fickenscher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles C. Fickenscher
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1861

8. AGE: Years	Months	Days	If less than one day
83	5	3	--hr. ---min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Not obtainable
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Charles C. Fickenscher
(b) Address 1028 Cathedral Street

17 (a) Burial (b) Date thereof 4/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

19 (a) APR 2 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 2-30 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Sept 1 1944 to March 31 1945 that I last saw him alive on March 30 1945

Immediate cause of death	Duration
Sudden Heart Failure	
Due to Chronic Endo and Myocarditis	15 Mos
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gibson Porter M.D.
Address 4822 Roland Ave Date signed 4/1/45

G27455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G27455 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chas. Edward Regan

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) about 1878

8. AGE: Years: about 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business At Large

FATHER
12. Name John J. Regan
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs T. O. Jones
(b) Address 916 Brightwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

vs APR 2 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945 to Same 19, and that I last saw him alive on March 28 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Jacob M. D.
Address 1700 Eutaw Place Date signed

X (17) Apr. 1-1945

G27456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 12B

G27456
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1748 S. Hanover Street
(c) Hospital or institution:

V3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1748 S. Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James C. Miles

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-01-6408

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1894

8. AGE: Years 50 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Petersburg, Va.
(Town, county, and state)

10. Usual Occupation Coppersmith

11. Industry or business Bethlehem Fairfield

FATHER
12. Name R. T. Miles
13. Birthplace Va.

MOTHER
14. Maiden Name Dora Kane
15. Birthplace Va

16 (a) Informant Mary Miles
(b) Address 1748 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Dyer
(b) Address 1217 St. Paul St.

19 (a) APR (Date rec'd by registrar) 2 19[illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1945 to March 29 1945, and that I last saw him alive on March 29 1945.

Immediate cause of death	Duration
(a) to dilitation of heart.	24 hours
Due to Mitral Regurgitation	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell
Address 1644 Hanover Date signed 3/31/45

Washington Nationals, M.D.

X

627457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

627457 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Mulliken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Broom.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Sep.

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Ridgeway S. C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Albert Broom
13. Birthplace S. C

MOTHER
14. Maiden Name Sarah
15. Birthplace S. C

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 1st /45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Winnsboro S C
Location S C

18 (a) Funeral director Elmer O Wilson
(b) Address 1000 Bradenbaugh

19 (a) APR 2 1945 Huntington Hill Registrar
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at 10.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Respiratory failure — Duration
Due to: Cerebrovascular hemorrhage
Due to: Hypertensive Cardiovascular disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Dieter
Address Johns Hopkins Hospital Date signed 3/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27458 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 E Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E Fayette St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Quill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Samuel Quill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) exact date unknown

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Madison Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Chas Jenkins
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jane Bishop
15. Birthplace Madison Md

16 (a) Informant Ella Foster (daughter)
(b) Address 1610 E Fayette st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location Laurel Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) (Date received by registrar) APR 2 1945 (b) Registrar Huntington Hilliard

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944, to March 30 1945, and that I last saw him alive on March 29 1945

Immediate cause of death Cerebral Hemmorrhage ½ Hemaplegia — Duration Sept 1944

Due to Generalized Arteriosclerosis

Due to

Other Conditions Senility, Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J Young M.D.
Address 1429 E Monument St Date signed 3/31/45

G27459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 E Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Mazeik

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Petronella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Petronella Mazeik
(b) Address 726 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Relay Md

18 (a) Funeral director Joseph Kaminskas Jr
(b) Address 602 Washington Blvd

DR (a) 2 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 19 , to Mar 30 1945, and that I last saw h.him alive on Mar 30 19 45.

Immediate cause of death Acute Cardiac Dilatation

Due to acute Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. C Feldman M. D.
Address 1440 E Balto Date signed 3/31/45

X

G37460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G37460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Harvey St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Dolly Thompson

3 (b) If veteran, name war: 0
3 (c) Social Security Account No. 0.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Robert Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1920

8. AGE: Years	Months	Days	If less than one day
25	1	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Clarence Kirby
13. Birthplace Maryland

MOTHER
14. Maiden Name Calaysta Konts
15. Birthplace Maryland

16 (a) Informant Mr. Francis Cain (Brother-in-law)
(b) Address 729 Harvey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Annex and Highways & Fleming
18 (a) Funeral director Hyman & Fleming Light St.
(b) Address 1436
19 (a) (Date rec'd by Registrar) Huntington Williams M.D. (Signature)

APR 7 1945
VS 168

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1945 to 3-31 1945, and that I last saw her alive on 3-30 1945.

Immediate cause of death	Duration
Spontaneous Sub-arachnoid Hemorrhage	
Due to	
Due to	
Other Conditions Endocarditis (mild) Mitral Stenosis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Leitch M.D.
Address Church Home & Hosp. Date signed 3-31-45

27461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

627461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4604 Arabia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4604 Arabia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM COSGROVE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	8	hr. min.

9. Birthplace Balto, Md
(Town, county and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name M. P. Cosgrove
13. Birthplace Ireland

MOTHER
14. Maiden Name Delia Cookahan
15. Birthplace Ireland

16 (a) Informant Thos. J. Cosgrove
(b) Address 1546 Patrobs Park Terrace

17 (a) Burial (b) Date thereof 4-3-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Balto, Md

18 (a) Funeral director Edward J. Fleming
(b) Address 1426 Light St.

19 (a) 2 1945 (b) Huntington for Williams M.R.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 10:25 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-31-45

462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 627462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 Mt Royal Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Mt Royal (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. B Williams Hay

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Hay
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Nov 17-1867

8. AGE: Years	Months	Days	If less than one day
77	4	14	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Grain Merchant
11. Industry or business

FATHER
12. Name J B Hay
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Balto

16 (a) Informant Bertha Hay
(b) Address 1520 Mt Royal

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 7 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2018 Arlington Ave

PR (a) 2 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 12:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1923, to April 1 1945 and that I last saw h. alive on March 24 1945

Immediate cause of death	Duration
Coronary Thrombosis	Immediate
Due to Coronary sclerosis	
Due to Generalized arteriosclerosis	
Other Conditions Chr Myocarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 2727 N Charles St Date signed Apr 1-45
Baltimore Md

VS 150

6-27463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6-27463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3125 Lawnview
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3125 Lawnview
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M Beigel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geo Beigel

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Oct 13-1885

8. AGE: Years 59 | Months 5 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Geo Beigel
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Trautman
15. Birthplace Balto

16 (a) Informant Geo Beigel
(b) Address 3125 Lawnview Ave

17 (a) Burial (b) Date thereof April 4 45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lawnwood Cem
Location Pikesville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) APR 2 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 17 1945, to Mar 31 1945 and that I last saw h[illegible] alive on Mar 30 1945.

Immediate cause of death: Acute heart failure — Duration

Due to: Bronchial Asthma

Due to:

Other Conditions: Hypertensive Cardio-Vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.

Address 3400 Eastern Ave Date signed 4/1/45

VS 150

G 27464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 27464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 E. Heath St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Beilein

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26. 1885

8. AGE: Years	Months	Days	If less than one day
59	10	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business Chamber of Commerce

FATHER
12. Name Michael Beilein
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schueler
15. Birthplace Germany

16 (a) Informant John Beilein
(b) Address 18 E Heath St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

APR 2 1945 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 19 45, at 3 20 AM

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. J. Gabrielli M.D.
Medical Examiner.
Date signed 4/1/45

VS 151

627465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 627465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA STS.
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Monticello Terrace (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME STANLEY McKIVITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife AUGUSTA McKIVITZ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1894

8. AGE: Years	Months	Days	If less than one day
50 51	8	14	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Clerk -
11. Industry or business Bethlehem Steel

FATHER
12. Name John KIVITZ
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Victoria Wisio
15. Birthplace Pennsylvania

16 (a) Informant wife
(b) Address 2916 Monticello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Aliceanna St

APR 2 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945 to 3/30 1945 and that I last saw him alive on 3/30 1945.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to CORONARY OCCLUSION	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. T. Spedden M. D.
Address Mercy Hosp, Date signed 3/31/45

G27466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

✓ G27466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 N Curley
(c) Hospital or institution: 6-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N Curley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John Wesley House

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Georgine House
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1865

8. AGE: Years 79 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (City or town, county, and state)

10. Usual Occupation carpenter

11. Industry or business

FATHER 12. Name John A House
13. Birthplace Balto

MOTHER 14. Maiden Name Don't Know
15. Birthplace Balto

16 (a) Informant Mrs Ruth Russell
(b) Address 2716 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

APR 2 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29/45 19 , at 10.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 19 44, to 3-29 19 44, and that I last saw h alive on 3-29 19 44-

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Dew M. D.
Address 720 E. Mon. St Date signed 3/30/45

VS 150

G-7467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 B

Registered No. G-7467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution:
Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott Cit
(If outside city or town limits, write RURAL and give town)
(d) Street No. Columbus Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E Brian

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Elizabeth Brian

6 (c) If five, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1870

8. AGE? Years	Months	Days	If less than one day
74	6	28	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired Board Chairman

11. Industry or business —

FATHER
12. Name William Edward Brian
13. Birthplace Md

MOTHER
14. Maiden Name Henrietta Wesley
15. Birthplace Md

16 (a) Informant Mrs Elmer Carey
(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-45 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director J C Higinbotham
(b) Address Ellicott City Md

19 (a) APR 2 1945 Registered by Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1945 to 3/30 1945 and that I last saw him alive on 3/30 1945

Immediate cause of death	Duration
Resp failure uremia - arteriosclerosis cardiovascular disease	
Due to Pericardial friction	
Due to Uremia	
Pericardial friction rub	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J W Mengel
Address Univ Hosp. Date signed 3/30/45 M. D.

G27468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G27468 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1446 Hanover St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1446 Hanover St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lydia M. Plaine

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Jesse Plaine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan ? 1862

8. AGE: Years	Months	Days	If less than one day
83	2	?	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name —

13. Birthplace —

MOTHER

14. Maiden Name —

15. Birthplace —

16 (a) Informant Family

(b) Address 1446 Hanover St.

17 (a) B. (b) Date thereof 4-7-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park.

Location Frederick Rd.

18 (a) Funeral director Jas. L. McCauley

(b) Address 1120 E. Fayette

19 (a) APR 2 1945 Huntington Williams, M.D. Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to March 29 1945. and that I last saw h[illegible] alive on March 29 1945

Immediate cause of death	Duration
Pneumonia.	2 Days
Due to Chronic Nephritis.	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature R. L. Campbell M. D.

Address 1646 Hanover St Date signed 3/31/45

G27469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G27469
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie K. Crawford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca Crawford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or Business

FATHER
12. Name Meyer Lair
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie —
15. Birthplace Russia

16 (a) Informant Rebecca Crawford
(b) Address 142 N. Broadway

17 (a) Burial 4-2-45
(Burial, cremation, or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Hebrew Y. M. & H. R. Assn
Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1139 E. Balto St.

APR 2 1945
(Date rec'd by registrar)
(b) Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/1945, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/1945 to 4/1/1945, and that I last saw him alive on 4/1/1945

Immediate cause of death Cardio-Respiratory failure; pulmonary oedema — Duration

Due to Myocardial infarction

Due to Arteriosclerotic Ht. Dis. Coronary sclerosis & insuff.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley H. Steinberg M.D.
Address Sinai Hospital Date signed 4/1/45

Stanley H. Steinberg

G27470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Russell

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Annie C. Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1880

8. AGE: Years 64 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Retired

FATHER
12. Name Wm. Russell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Clayton V. Russell
(b) Address 522 S. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) Date rec'd APR 2 1945 (b) Huntington, Maryland

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Hypostatic Pneumonia
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fahrenholz M.D.
Medical Examiner.
Date signed 3/31/45

G-27471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G-27471 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light + Street
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Race Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H ~~Ernst~~ (Ernst)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-09-6220

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	divorced

6 (b) Name of husband or wife ~~Sept 27, 1884~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1884

8. AGE: Years	Months	Days	If less than one day
60	6	3 4	hr. min.

9. Birthplace Balto. City (Town, county, and state)

10. Usual Occupation Watchman B+O R.R.

11. Industry or business

FATHER 12. Name Simon Ernst

13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea

15. Birthplace Germany

16 (a) Informant John Ernst

(b) Address 2620 Frogman ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto

18 (a) Funeral director A. Howard Evans

(b) Address 4a W Chas St

19 (a) APR 2 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945, at 2:35 PM

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. R. Davis M.D. (Medical Examiner.)

Date signed 4/1/45

G27472

456472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G27472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1358 Loathourin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-40

8. AGE: Years	Months	Days	If less than one day
4	10	6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathaniel Brooks
13. Birthplace Va.

MOTHER
14. Maiden Name Helen Alexander
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4-4-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mr. Leo. T. A. Gibson
(b) Address 1735 Druid Hill Ave.

19 (a) 1945 (b) Huntington Williams M.D.
(Date of registration) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March-30 1945 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-30 1944 to March-30 1945 and that I last saw h.r. alive on March-30 1945

Immediate cause of death: Congestive heart failure — Duration 1½ yr.

Due to: Chronic nephritis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis W. Nelfield M. D.
Address Johns Hopkins Hospital Date signed 3-31-45

X

173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G27473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital 11 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Madison ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F. Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	6	hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Janitor Custodian

11. Industry or business

FATHER 12. Name Charles Conner

13. Birthplace Va

MOTHER 14. Maiden Name Harriett ??

15. Birthplace Va

16 (a) Informant Teresa Mickens

(b) Address 1605 Mt. Cullah St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee A. Mulland

(b) Address 1691 Druid Hill Ave.

19 (a) APR 2 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30-45 19 , at 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7-45 19 , to 3-30-45 19 , and that I last saw h[illegible] alive on 3-30-45 19 .

Immediate cause of death	Duration
Bronchogenic Carcinoma	
Due to	
Due to	
Other Conditions Pulmonary abscess	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchoscopy; Pul. Abscess

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank G. Brady M. D.

Address Md. Gen. Hosp. Date signed 3-31-45

X

G27474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579 Registered No. G27474

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: St. Joseph's Hosp
(a) Baltimore City, Maryland
(b) Street address 1941 E. Edwards St.
(c) Hospital or institution: Lee Francis Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Bureley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kathleen Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Baby.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar-31-1945

8. AGE: Years | Months | Days | If less than one day: 5 hr. 40 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hammond
13. Birthplace Penna.

MOTHER
14. Maiden Name Katherine E Weber
15. Birthplace Baltimore Md

16 (a) Informant Lloyd Joyner
(b) Address 1313 Rutland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2-1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore Md.

18 (a) Funeral director Jamie Cook Lyfer
(b) Address 1700 N. North Ave

19 (a) 4-2-1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1945 to April 1 1945 and that I last saw her alive on Mar 31 1945.

Immediate cause of death	Duration
Premature birth	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address St Joseph's Hospital Date signed 4-4-45

VS 150

7475

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G27475

CERTIFICATE OF DEATH 83a

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 726 East 21st Street

How long in hospital or institution? 3 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)

State Maryland County Kent

City or town Worton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Worton R.D # 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John William Copper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife (late) Lama I Cooper

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 10 1862

8. AGE: Years	Months	Days	If less than one day
82	7	20 27	..... hrs. ..... min.

9. Birthplace Kent County Maryland
(Town, county, and state)

10. Usual occupation retired farmer

11. Industry or business farm

FATHER 12. Name John W. Cooper

13. Birthplace Delaware

MOTHER 14. Maiden name Rachel Ackinson

15. Birthplace Kent Co Maryland

16. Informant Mrs. Sarah V. Williams (Daughter)

Address Worton, Kent Co. Maryland

17. Burial Date thereof 4/4/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Still Pond

Location Still Pond, Kent Co. Maryland

18. Funeral director Marion V. Williams

Address Chestertown, Maryland

19. APR 2 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 3, 45 to Apr 1st 1945 and that I last saw h... alive on Apr 1st 1945

Immediate cause of death Cardiac Failure — DURATION

Due to Cerebral Apoplexy —

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur C Manninger M. D., Coroner

Address 800 E North Ave Date signed 4/2/45

G27476 G27476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 North Linsene Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 N. Linsene Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis McKinney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1866

8. AGE: Years	Months	Days	If less than one day
78	6	14	hr. min.

9. Birthplace Willmington Delaware (Town, county, and state)
10. Usual Occupation Leather glazer
11. Industry or business

FATHER
12. Name James McKinney
13. Birthplace Ireland

MOTHER
14. Maiden Name Susan Roberts
15. Birthplace Ireland

16 (a) Informant John Menton
(b) Address 1429 N. Linsene Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Lancaster Pa.

18 (a) Funeral director John C. Miller & Son
(b) Address 2465 East Oliver St.

19 APR 2 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940 to April 1 1945.
and that I last saw h[illegible] alive on March 30 45

Immediate cause of death Congestive heart failure — Duration
Due to arteriosclerosis hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jack J. Singer M.D.
Address 506 E North Ave Date signed 4-4-45 M. D.

VS 150

G27477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G27477
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison
(c) Hospital or institution:
Md General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 E Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bonnie Lee Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27th 1942

8. AGE: Years	Months	Days	If less than one day
2 2½	6	4	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Alvin Moore
13. Birthplace Md

MOTHER
14. Maiden Name Edna Ruth
15. Birthplace Md

16 (a) Informant Mr Alvin Moore
(b) Address 2431 E Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3rd 1945 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E North Ave Est

18 (a) Funeral director Leo G. Cook
(b) Address 1701-05 N Patterson Park Ave

19 (a) APR 2 1945 (Rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1945, at 8 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945 to 3/31 1945, and that I last saw h.er alive on 3/31 1945.

Immediate cause of death

Generalized abd. peritonitis

Due to Ruptured appendix

Due to

Other Conditions

Duration
5 days
?

(Include pregnancy within 3 months of death)

Date of operation 3/31 1945

Major findings of operation: Ruptured appendix & generalized peritonitis

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Rayner M. D.
Address Md. Genl. Hosp. Date signed 3/31/45

G27478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G27478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Clifton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Howard Mandler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1316

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Nellie R. Mandler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1883 | 1884

8. AGE: Years 60 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation machinist

11. Industry or business

FATHER — 12. Name Charles J. Mandler
13. Birthplace Balto.

MOTHER — 14. Maiden Name Amelia Bruen
15. Birthplace Balto.

16 (a) Informant Mrs. Nellie R. Mandler
(b) Address 2014 Cliftwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 4/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director Philip Herring Son
(b) Address 2024 Orleans St

(a) APR 2 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1-45 19 , at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1945 to 4-1-45 19 , and that I last saw him alive on 4-1-45 19 .

	Duration
Immediate cause of death: Cardiac Failure	
Due to	
Due to	
Other Conditions: Lobar pneumonia	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank P. Brady M. D.
Address Md. Gen. Hosp. Date signed 4-1-45

G27479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27479 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7006 Park Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celia Helprin
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Benjamin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-20-89
8. AGE: Years 55 Months Days 12 If less than one day hr. min.
9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business
FATHER 12. Name Jacob Deutsch
13. Birthplace Austria
MOTHER 14. Maiden Name Lena ?
15. Birthplace Austria
16 (a) Informant Records (b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Wellwood Cemetery Location Long Island N.Y.
18 (a) Funeral director S. L. Levinson Bro.
(b) Address 11 24 26 W North ave
19 (a) APR 2 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 5 05 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1945 to April 1 1945 and that I last saw her alive on April 1 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary thrombosis	
Due to Hypertension and arterio-sclerotic cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abraham Rencier M.D.
Address Johns Hopkins Hospital Date signed 3/2/45

VS 100

G27480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Leadenhall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex C

5. Color or race M

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Chas E Hughes

(b) Address 812 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/41 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Isaac L Bosemeyer

(b) Address 108 W Montgomery St

19 (a) Registered by [illegible] Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1941, at 3 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature P. J. Sulowski M.D.
Medical Examiner.

Date signed 3/29/41

G27481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27481 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 E Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lowe Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. 279-03-2690

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Mar

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5th 1851

8. AGE: Years 93 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Penn
(Town, county, and state)

10. Usual Occupation Ship Fitter

11. Industry or business Fairfield S. Yards

FATHER 12. Name Charles H. Lowe Sr

13. Birthplace Penn

MOTHER 14. Maiden Name Martha Walsh

15. Birthplace Penn

16 (a) Informant Mrs G Lowe

(b) Address 435 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1st 1945 (month) (day) (year)

(c) Cemetery or crematory

Location Johnsons City Penn

18 (a) Funeral director Leo G. Cook

(b) Address 1701-03 N Patterson Park ave

19 (a) (b)
(Signature of registrar) Registrar

APR 2 1945
VS 160 Washington Witness, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31st 1945, at 2.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1945, to 3-31 1945, and that I last saw him alive on 3-31 1945.

Immediate cause of death: Cerebral hemorrhage — Duration 2 hrs

Due to: Hypertensive CVD — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy B. Turner, Jr. M. D.

Address Mercy Hospital Date signed 4/3/45

G27482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

Registered No. G27482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 St Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia F. Mudge.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 1879.

8. AGE: Years	Months	Days	If less than one day
65	7	7	hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Wilson
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Zantzinger
15. Birthplace Virginia

16 (a) Informant Mrs. Richard Ball
(b) Address 5415 Falls Rd Terrace.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 806 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VR APR 2 1945

4/1/45 **MEDICAL CERTIFICATION**

20. DATE OF DEATH 4/1/1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945 to (3 Hrs) 19 , and that I last saw h[illegible] alive on 3-1 1945.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchijah Spragins M.D.
Address [illegible] M. D. Date signed 4-1-45

G27483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945

G27483 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where data are not known, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 742 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 742 W Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife George Chester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1897

8. AGE: Years 47 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Gloucester - Va
(Town, county, and state)

10. Usual Occupation Home -

11. Industry or business

FATHER
12. Name George Blaney
13. Birthplace West Berry N.C.

MOTHER
14. Maiden Name Jennie Chambers
15. Birthplace Gloucester - Va

16 (a) Informant George Chester
(b) Address 742 W Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Justin R Williams
(b) Address 322 N Schroeder St

19 (a) APR 2 1945 Huntingtor Williams, M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 29 1945, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar - 29 1945 to Mar 29 1945, and that I last saw h[illegible] alive on Mar 29 1945

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to (b) Hypertension	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David J Wexler M. D.
Address 172 W Lee Date signed 3/31/45

X

G27484 G27484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3337 Paine St.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3337 Paine St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME James E. Gill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose A. Gill

6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) Sept. 12-1865

8. AGE: Years 79 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Fredericksburg Va (Town, county, and state)

10. Usual Occupation Retired Waste Paper dealer

11. Industry or business

FATHER
12. Name Felix Gill
13. Birthplace Va

MOTHER
14. Maiden Name Susan Kerr
15. Birthplace Va

16 (a) Informant Mrs. Rose A. Gill.
(b) Address 3337 Paine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md.

18 (a) Funeral director Geo. L. Berger Jr.
(b) Address 1512 Hollins St.

19 (a) APR 2 1945 Registered by Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1945 to Mar. 29 1945, and that I last saw him alive on Mar. 25 1945

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerosis C.-V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Edw. L. Gladmon M.D.
Address 403 Dalle Rd. Date signed 4/2/45

G27485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G27485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day 1hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Anna Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Charles R. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1912

8. AGE: Years	Months	Days	If less than one day
33	1	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Zeller
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ottilia Huber
15. Birthplace Balto. Md.

16 (a) Informant Mr. Charles R. Myers
(b) Address 1910 N. Longwood St.

17 (a) Burial (b) Date thereof 4/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) APR 21945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1945, at 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 31, 1945 to April 1, 1945, and that I last saw her alive on April 1, 1945.

Immediate cause of death	Duration
Metastatic Carcinoma	
Due to Carcinoma, Left Breast	5 Mos. +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. D. Speed III M. D.
Address Woman's Hospital Date signed 4-1-45

X

34475! G27486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 B G27486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Use correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Longwood, St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F. Mc Cleary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Genevieve Mc Cleary

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Lab. technician

11. Industry or business Consol. Gas. Co.

FATHER 12. Name Charles E Mc Cleary

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Ulrich

15. Birthplace Delaware

16 (a) Informant records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 4/45 (month) (day) (year)

(c) Cemetery or crematory Carrolls Chapel

Location Chestnut Ridge, Balto Co Md

18 (a) Funeral director John D. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by Registrar) 1945 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 - 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23- 1945 to 4-1- 1945 and that I last saw him alive on 4-1- 1945

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Hodgkin's disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. K. M'Lean

Address J. H. H. Date signed 4/7/45

VS 150

X

HOHMAN

G27487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G27487 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light Street
(c) Hospital or Institution South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 - 2nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Hohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widower

6 (b) Name of husband or wife Anna M. Hohman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Christopher Hohman
13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Lumbach
15. Birthplace Germany

16 (a) Informant Mrs. Marie E. Plaine
(b) Address 3708 - 2nd Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Annapolis Blvd.

18 (a) Funeral director John F. Kenny Inc
(b) Address 716 Light St.

19 (a) Rec'd by [illegible] 2 1945 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/45, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/45 to 3/30/45 and that I last saw him alive on 3/30/45

Immediate cause of death	Duration
Decompensation	
Due to Hypertension	
Due to	
Other Conditions Arterio & Clerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. Dr. Caraway M.
Address 5 Bolton St. Hop. Date signed 3/31/45

G27488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G27488 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGINS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 S. Regester st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 S. Regester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malissa Reeves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Fayetteville, N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Edgar Robinson
13. Birthplace N.C.

MOTHER
14. Maiden Name Susanna Robinson
15. Birthplace N.C.

16 (a) Informant Jasper Robinson
(b) Address 18 S. Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Leroy O. Wilson
(b) Address 1000 Bright Boy Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS APR 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 2, 1945, to March 31 1945; and that I last saw h.e.r. alive on March 26 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R.M. Pincelli M. D.
Address 1422 E. Chase Date signed 4-2-45

G27489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G27489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 51 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 51 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Thaxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ora Thaxton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1902

8. AGE: Years 42 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace South Boston, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Batie Thaxton

15. Birthplace Va

16 (a) Informant Ora Thaxton

(b) Address 51 N. Caroline st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Nelson

(b) Address 1000 Bradley

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150 APR 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3·30·1945, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5·30 1945, to 3·30 1945 and that I last saw h alive on 3·30 1945.

Immediate cause of death Acute Myocarditis — Duration: ?

Due to Cerebral apoplexy — ?

Due to Hypertension — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Levey M. D.

Address 1420 E. Chase Date signed 3·31·45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G27490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G27490 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Aliceanna St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Editta Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/44

8. AGE: Years | Months: 5 | Days: 13 | If less than one day ....hr. ....min.

9. Birthplace Md — (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ethel Williams

13. Birthplace Va.

MOTHER 14. Maiden Name Ethel Williams

15. Birthplace Va.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Brant Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31- 1945, at 2:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1945, to 3-31 1945, and that I last saw h[illegible] alive on 3-31 1945.

Immediate cause of death	Duration
Diarrhea - ? non specific	
Due to Pneumonia, R.U.L.	
Due to Otitis media, bilateral	
Other Conditions Dehydration fr shock	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address J H H Date signed 4/4/45

VS 100 APR

G27491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27491 Registered No.

B-92792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arthur Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Seperated

6 (b) Name of husband or wife Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1901

8. AGE: Years	Months	Days	If less than one day
43	8 10	12	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Oliver
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pleasant St. Huntington Pharmacy

19 (a) (Date rec'd by registrar) (b) Registrar

VS 186

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 1- 1945, at 10.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27- 1945, to 4-1- 1945, and that I last saw him alive on 4-1- 1945

Immediate cause of death: Cardiac insufficiency — Duration: 5 days?

Due to: Hypertension and arteriosclerosis 5 years.
Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Dorsal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

M. D. Signature E Woodward
Address Baltimore City Hospitals Date signed 4-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

G27492 MILLER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G27492 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4314 Sheldon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 Sheldon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Mr (or) Anthony Miller (or) Miles

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-12-9919

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary G.

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Aug 1866

8. AGE: Years 78 | Months 7 | Days | If less than one day: hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Anton Milus
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Chester A. Millar
(b) Address 4314 Sheldon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 2 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Martin McG. Dugan
(b) Address 4110 Belair Rd.

19 (a) APR 2 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 45 at 6:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 19 45 to March 30 19 45 and that I last saw h[illegible] alive on March 27 1945

Immediate cause of death Chronic Myocarditis

Due to Arteriosclerosis

Due to Nephritis, Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.

Address 3001 Eastern Date signed

X Due 3/30/45

G27493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

G27493 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Green St.
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 959 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: ~~Catherine Miller~~ Catherine Miller

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 10, 1902

8. AGE: Years: 39 42 | Months: 4 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: Mr. William Barry
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Bridget Timmons
15. Birthplace: Ireland

16 (a) Informant: Mr. Albert Miller
(b) Address: 959 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 3, 1945 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cemetery
Location: Woodlawn, Md.

18 (a) Funeral director: Willis Lamontagne
(b) Address: 1003 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar:

APR 2 1945

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-31-45 19 at 845 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1945 to 3-31 1945 and that I last saw her alive on 3-31-45 19

Immediate cause of death: Toxemia Septicemia — Duration:

Due to: Pneumonia - Hemolytic Strep Type 19

Due to:

Other Conditions: Paresis - CVS Lues

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: D Gleason M. D.

Address: Univ Hosp Date signed: 3-31-45

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G27494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G27494 Registered No.

MAKE NO RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 N.Kenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
Md.
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N.Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna C.I.Hokanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife August Hokanson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.2-1879

8. AGE: Years	Months	Days	If less than one day
65	6	29	hr. min.

9. Birthplace Germany
(City, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Wellmann
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Sister Mc Handley
(b) Address 127 N. Kenwood Ave. Apr 11 3/45

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave.

18 (a) Funeral director John F. Miller
(b) Address 2234 Jefferson St.

19 (Date received by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944, to March 31 1945, and that I last saw h alive on March 31 1945

Immediate cause of death Cerebral Hemorrhage — Duration 3/27/45

Due to Arterio Sclerosis — 1942

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roemer, M. D.
Address 801 N Kenwood Ave Date signed 4/2/45

G27495 HEALTH DEPARTMENT—CITY OF BALTIMORE G27495

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 Park Heights Ave St. 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Ellen Jane Moore

If U. S. Veteran specify WAR

(a) Residence: No. 715 Park Heights Ave St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	S.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Oct 3, 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	5	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

FATHER

13. NAME Henry Moore

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

MOTHER

15. MAIDEN NAME Martha Donalson

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Mrs. Edgar Henley

(Address) 715 Park Heights Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Olivet Date 4-3 1945

19. UNDERTAKER Young Byers

(Address) 5005 Park Heights Ave

APPROVED 3 1945 Hattie for Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 30 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb 1 1945 to March 26 1945

I last saw her alive on March 26 1945 Death is said to have occurred on the date stated above, at 9.30 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia	2-1-45

Other contributory causes of importance:

Cardiovascular Disease

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A. W. Kaz M. D.

(Address) 3862 Dolfield Ave

V8 3

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

G27496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45D

Registered No. G27496

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3365 Frederick Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3365 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Lutz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Theresa Lutz
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 27th 1878

8. AGE: Years	Months	Days	If less than one day
66	8	5	..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Teamster
11. Industry or business Own

FATHER
12. Name Joseph Lutz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rose Grise
15. Birthplace Balto Md.

16 (a) Informant Mrs Theresa Lutz
(b) Address 3365 Frederick ave

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 4/4/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) 1 E Saint Paul St

APR 3 - 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1945, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1944 to 4/1 1945 and that I last saw h~~im~~ alive on 4/1 1945

	Duration
Immediate cause of death: General Carcinomatosis	2 Months
Due to: Carcinoma left upper jaw	7 Months
Due to:	
Other Conditions: Coronary Thrombosis	6 Months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Eliot W Johnson
Address 3432 Druid Hill Ave Date signed 4/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 130

27497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 527497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Rose St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret May

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	WIDOW

6 (b) Name of husband or wife: FREDERICK C. MAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAR. 5 1887

8. AGE: Years	Months	Days	If less than one day
58	0	26	hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: SCOTLAND

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: SCOTLAND

16 (a) Informant: ALBERT C. MAY (SON)
(b) Address: 620 S. ROSE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 3/45 (month) (day) (year)
(c) Cemetery or crematory: SACRED HEART
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST.

19 (Date received by registrar) APR 3 - 1945 (Signature of registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 8 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 31 1945 6 P M.
(b) Where did injury occur? Loolem Ave & Rose St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury pedestrian struck by auto

23. Signature Robert Co Graham M.D. (Medical Examiner)
Date signed April 12, 1945

G27498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 a

Registered No. G27498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mount Hope Retreat

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 5 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 5 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 600 S. Conkling St. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Rev. Henry Borgmann, C.Ss.R.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1868

8. AGE: Years 77 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER

12. Name Henry Borgmann

13. Birthplace Germany

MOTHER

14. Maiden Name Adelaide Maier

15. Birthplace Germany

16 (a) Informant Mount Hope Retreat

(b) Address 6420 Reisterstown Road, Balto

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 5/45 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 402 S. WOLFE ST.

19 (a) APR 3 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1943, to Apr. 2 1945, and that I last saw him alive on Apr 2 1945

Immediate cause of death	Duration
Left Cerebral hemorrhage	4 days
Due to General Arteriosclerosis	
Due to	
Other Conditions Senile Depression	1 yr 6 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. J. Clancy M. D.

Address 336 Fredrick Ave Signed

G27499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 N. Milton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA M. MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1871

8. AGE: Years	Months	Days	If less than one day
73	9	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name - Beckman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. George A. Miller
(b) Address 308 N. Hilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 3 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1940, to 19, and that I last saw h[illegible] alive on 3/31/45 19.

Immediate cause of death	Duration
Coronary occlusion	2 weeks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Bauer
Address 1501 N. Milton Ave Date signed 4/2/45 M. D.

VS 150

7500 X ✓ G27500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109

Registered No.

JO #92427

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Marlyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Massey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1893

8. AGE: Years 52 | Months -1- | Days 17 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Fairfield Shipyard

FATHER
12. Name Mandeville (d)
13. Birthplace West Virginia

MOTHER
14. Maiden Name Minerva Burnside (d)
15. Birthplace West Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 29 1945

18 (a) Funeral director Commissioner of Health
(b) Address

1945 APR 3 (Date rec'd by registrar) (c) Hattie Mae Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1945 to March 23 1945, and that I last saw him alive on March 23 1945

Immediate cause of death	Duration
Cardiac failure	1 hour
Due to unresolved pneumonia	3 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Allen M. D.
Address Balto City Hosp. Date signed 3/24/45

correct age is especially important. Physicians, please

2025 X

G27501 X V G27501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Alexander Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2285 York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kline, Baby Boy Kline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M (twin) | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/45

8. AGE: Years | Months | Days 2 | If less than one day ....hr. ....min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Kline, Forest

13. Birthplace Penna

MOTHER 14. Maiden Name Walter, Martha

15. Birthplace Penna

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAR 29 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 APR 3 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1945 at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1945 to 3-27 1945 and that I last saw h[illegible] alive on 3-24 1945

Immediate cause of death Respiratory failure — Duration

Due to Pneumonia atelectasis — 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: [illegible]

of autopsy: Bronchopneumonia atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm L. Mullen M. D.

Address 6 East Eager St Date signed 3-28-45

2621 Balto 2, Md X

G27502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G27502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Merrymans Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FRANCIS BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1	23 M		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 29 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (b) Huntington Williams, M.D.
APR 3 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1945, at 11:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Mongolian Idiocy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 13 1945

G27503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G27503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 N Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Roesch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mollie C. Roesch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1875

8. AGE: Years	Months	Days	If less than one day
70	0	16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER 12. Name Frank Roesch
13. Birthplace Germany

MOTHER 14. Maiden Name Theresa Kuntzman
15. Birthplace Germany

16 (a) Informant Mr James A Welch
(b) Address 81 W Elmora Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Albert F Hilz
(b) Address 1604 N Chester St

APR 3 - 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/1945 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/1945 to 4/1/1945, and that I last saw him alive on 4/1/1945.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph A Long M.D.
Address Date signed 4/2/45

Huntington Williams, M.D. Registrar

VS 150

G27504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G27504

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 Echodale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Echodale Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred J. Jung

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife James L. Jung
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1893

8. AGE: Years	Months	Days	If less than one day
51	4	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Martin W. E. Dippel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Connelly
15. Birthplace Baltimore, Md.

16 (a) Informant Martin J. Jung
(b) Address 2909 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Ann Sts.

19 (a) (Date rec'd by Local Reg.) (b) Huntington Williamsport, Md. Address 2727 St. Paul St. Date signed 4/3/45

APR 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945 at 4:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to April 2 1945 and that I last saw h[illegible] alive on March 31 1945.

Immediate cause of death Coronary Thrombosis — Duration 7 days

Due to Myo-carditis — Duration Several years

Due to Arteriosclerosis — Duration Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster, M.D.

G27505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G27505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 884 W Fairmont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Pinkney Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife January 10.1893
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10.1893

8. AGE: Years	Months	Days	If less than one day
51	3	23	hr. min.

9. Birthplace Eastern Shore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Louise Holmes Daughter
(b) Address 884 W Fairmont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph J. Sipsky
(b) Address 404 N Mount Street

19 (a) Date received by Registrar APR 3 1945 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1945 at 5:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1945, to 4/2 1945 and that I last saw h alive on 4/2 1945.

Immediate cause of death (Duration)

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R C Flannigan M.D.

Address Univ. Hosp. Date signed 4/2

G27506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2756 Pelham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2756 Pelham ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Theresa Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Schaefer | 6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 7-1870

8. AGE: Years 74 | Months 9 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Falck

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Dellmann

15. Birthplace Germany

16 (a) Informant Mr John D Schaefer

(b) Address 2756 Pelham ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Balto Md

18 (a) Funeral director Jos. D. Herrtom

(b) Address 3601 Kentucky ave

19 (a) ... (Date rec'd by registrar) (b) ... Hunting for Hillcrest Md

APR 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15, 1945 to April 1, 1945, and that I last saw her alive on March 31, 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 mos.
Due to: Arteriosclerosis	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L. Pesagno M. D.
514 Drury Lane Date signed April 2, 1945.

Pesagno X

G27507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

Registered No. G27507

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 Sheffield Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Sheffield Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Atkins Burton

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 220-07-2279

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Thelma C. Burton

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Jan 21. 1917

8. AGE: Years	Months	Days	If less than one day
28	2	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Police

11. Industry or business B & O. R R.

FATHER
12. Name Harold Atkins Burton, Sr.
13. Birthplace King & Queen co. Va.

MOTHER
14. Maiden Name Jane M. McKann
15. Birthplace Middlesex Co. Va.

16 (a) Informant Mrs Thelma C. Burton
(b) Address 1507 Sheffield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 3-1945 (Date received by registrar) (b) Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 45 6:15 P. M. (19 ..., at ...)

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound of Brain

Due to

Other Conditions Unpondered

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-30-45 at 6:20 P. M.
(b) Where did injury occur? 1507 Sheffield Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Firearm - revolver

23. Signature Howard J. Bluedorn M.D. Medical Examiner.
Date signed 3-31-45

G27508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 a

G27508 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Stratford Apts.
(c) Hospital or institution: Hilton + Liberty Hgts. Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Stratford Apts. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle May Brown

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife J. Wilson Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1889

8. AGE: Years	Months	Days	If less than one day
55	3	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Collector
11. Industry or business Collection Agency

FATHER
12. Name Christopher Seboor
13. Birthplace France

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mabel V. Brit (sister)
(b) Address 731 S. Linwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sauerwein Inc.
(b) Address North Ave. & Broadway

19 (a) APR 5 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1945, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage, Cerebellum
Spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Rhoades M.D. Medical Examiner.
Date signed April 2, 1945

G27509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

G27509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hosp
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Carswell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustavus Niemeyer

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-09-1294

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Fannie Blanche Dugent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1876

8. AGE: Years 68 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Time keeper

11. Industry or business Beth. Steel Co. Sp.Pt

FATHER
12. Name Frederick W. Niemeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Magdalena Schildknecht
15. Birthplace Germany

16 (a) Informant Mr. Frederick W. Niemeyer
(b) Address 1745 Carswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 3 1945 (Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 50

20. DATE OF DEATH March 31 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 30 1945, to Mar 31 1945
and that I last saw h[illegible]m alive on March 30 1945

Immediate cause of death: Acute hepatitis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 3-31-45

X

G27510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27510 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 157 W. Henrietta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 W. Henrietta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Gantt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1882

8. AGE: Years	Months	Days	If less than one day
63	6	2	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Custis
13. Birthplace Va

MOTHER
14. Maiden Name Julia Piney
15. Birthplace md

16 (a) Informant John Thomas Gantt
(b) Address 157 W. Henrietta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 5-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director James A Hayes
(b) 2 W. Fitch St.

19 (a) APR 3 1945 (Date rec'd by registrar) (b) Huntington Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1945, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D. Medical Examiner.
Date signed 4/2/45

G27511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27511 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 E North Ave
(c) Hospital or institution: 9th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Same
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel F. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1859

8. AGE: Years 86 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Thompson
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia ?
15. Birthplace Ireland

16 (a) Informant Helen J. Thomas
(b) Address 710 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery or crematory New Cath
Location Old Frederick Rd.

18 (a) Funeral director John J. Wilson
(b) Address 300 E. Balto. St.

19 (a) Filed APR 3 1945 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10th 1945 to Apr. 1st 1945 and that I last saw him alive on April 1 1945

Immediate cause of death Chronic Myocarditis

Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Rosenthal M. D.
Address 1907 Greenmount Ave Date signed 4/7/45

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

472

G27512 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (~~year~~ ~~month~~ days) 17 days
(e) Length of stay in Baltimore (yrs., ~~month~~, or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 N. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Thiess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age 1687

7. Birth date of deceased (mo., day, yr.) 9-17-1887

8. AGE: Years 57 | Months 6 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business liquor

FATHER 12. Name Henry L. Theiss

13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Ann McNamee

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Thelma McClellan

(b) Address 134 N. Potomac ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Rd.

18 (a) Funeral director Salem G. Moan

(b) Address 300 E. Baltimore St.

19 (a) (b) APR 3 - 1945
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 8:39 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1945 to 3/30 1945 and that I last saw him alive on 3/30 1945

Immediate cause of death Resp. Failure — Duration

Due to Carcinoma of Larynx

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 3/16/45

Major findings of operation: Carcinoma of larynx

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. O'Donnell M. D.

Address Mercy Hosp. Date signed 3/30/45

X

G27513 | BALTIMORE CITY HEALTH DEPARTMENT | G27513

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Amity St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Bingley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Charlestown - S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Sarah E. Stewart
(b) Address 6 - S Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Chapel Hill - Annap. Blvd

18 (a) Funeral director Mrs Walter R. Williams
(b) Address 3224 Schroeder St.

19 (a) (Date rec'd by Registrar) APR 2 (b) 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945 at 12 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Civ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cortico sclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gretter M.D.
Medical Examiner.
Date signed March 31 1945

G27514

AB02744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH #4B

✓ G27514 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Paca St-Mt.Winans (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Burley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-4-1875

8. AGE: Years	Months	Days	If less than one day
69	5	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Dave Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Wise
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) APR 3 1945 (Date rec'd by registrar) (b) Registrar

Hunting & Williams U.F.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29- 1945; at 9.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24- 1945, to 3-29 1945, and that I last saw her alive on 3-29- 1945

Immediate cause of death Cerebral accident? (probably thrombosis) — Duration 7-8 hrs?

Due to

Due to

Other Conditions Hodgkins disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C E Burns Jr. M. D.
Address City Hosp. Date signed 3-30

83a

G27515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G27515 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 115
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Roadlee Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nancy Ruth Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/45

8. AGE: Years	Months	Days	If less than one day
		17 D	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Marvin Frank
13. Birthplace Balto

MOTHER
14. Maiden Name Celia Gallant
15. Birthplace BALTO

16 (a) Informant ~~Father~~ Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom Memorial Park
Location Windsor Mill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1781 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS APR 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-45 19 , at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 4/3 1945, and that I last saw her alive on 4/3 1945

Immediate cause of death	Duration
Congenital Heart Disease?	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Paul Fenton M. D.
Address Date signed

X

G27516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G27516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland St. & Bonyne Ave
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katie M Stern

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-1668

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Samuel Stern
13. Birthplace Warsaw

MOTHER
14. Maiden Name Fannie
15. Birthplace Warsaw

16 (a) Informant Hospt. Records
(b) Address

17 (a) Burial (b) Date thereof 4-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Conkling Sts.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) Hattie Livingston Williams

APR 3

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1945 to April 1 1945, and that I last saw her alive on April 1 1945.

Immediate cause of death Auto Coronary Thrombosis - Cerebral infarction — Duration

Due to Hypertension, cardiovascular disease

Due to Angina Pectoris

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rachel W Bradshaw M. D.
Address West Baltimore General Hosp. Date signed 4-1-45

G27517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G27517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Ga. Co.
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Sidle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-45

8. AGE: Years | Months | Days: 17 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank A Sidle
13. Birthplace Md.

MOTHER
14. Maiden Name Miriam Beard
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location
18 (a) Funeral director Jos Lewis Inc
(b) Address 1429 E. Balto. St.
19 (a) (Date rec'd by Registrar) 1945 Huntington Williams, M.R. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945 at 12.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1945 to Apr 2 1945 and that I last saw h. alive on April 2 1945

Immediate cause of death: Pulmonary Edema — Duration

Due to

Due to

Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
JHH
Address Date signed

G27518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G27518 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 DeSoto Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Clara Shrouds Shrouds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1941

8. AGE: Years 3 | Months 4 3 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph D Shrouds

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Madeline Hamlen

15. Birthplace Cecil Co. Md.

16 (a) Informant Joseph Shrouds

(b) Address 1015 DeSoto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md

18 (a) Funeral director Wolfe & Boarman Inc

(b) Address 1217 St Paul St.

19 APR 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1945, at 7:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy - Bon Secours Hospital and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull c Subdural hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/2

(a) Date of injury 3/31/45 at 12:00 Noon M.

(b) Where did injury occur? 1015 DeSoto Rd

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? —

(d) Means of injury Fall down stairs -

23. Signature C. F. Leibrandt M.D. Medical Examiner.

Date signed 4/5/45

G27519

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G27519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: North
(a) Baltimore City, Maryland
(b) Street address 1349 Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1349 W. Fremont Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary E. Burrell
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex F
5. Color or race Col
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4 / 2 / 45
8. AGE: Years | Months | Days 1 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, or state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Wm Burrell
13. Birthplace Md

MOTHER
14. Maiden Name Ruby Lamack
15. Birthplace Md

16 (a) Informant William Burrell
(b) Address 1349 Fremont Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 / 3 / 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Leo L. Belay
(b) Address 203 Washington Blvd
19. (a) 4-3-1945 (Date filed by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 1945, at 8 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1945, to 4-2 1945, and that I last saw h... alive on 4-2 1945.

Immediate cause of death Prematurity — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Julius Shrute M. D.
Address 1843 Penna Ave Date signed 4-3-45

VE 3

G27520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120B

Registered No. G27520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Franklin Square Hosp't

(c) Hospital or institution: Calhoun & Fayette Sts. 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1311 Hollins St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Martin Shanahan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine M.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 21, 1887

8. AGE: Years	Months	Days	If less than one day
58		12	hr. min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Michael Shanahan

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Butler

15. Birthplace Ireland

16 (a) Informant Mrs. Catherine M. Shanahan

(b) Address 1311 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Old Fred. Rd.

18 (a) Funeral director John Coward & Son

(b) Address 900-03 Hollins St.

19 APR 3 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 1945, at 2.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1945 to 4-2 1945 and that I last saw him alive on 4-2 1945

Immediate cause of death generalized peritonitis

Duration 2 wks

Due to ruptured ulcer of ileum

Due to

Other Conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation 4-1-45

Major findings of operation: Ruptured ulcer of ileum & peritonitis

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bobby L. Jones, M.D.

Address Franklin Square Hosp. Date signed 4-2-45

VS 150

G27521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. G27521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rasperburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Leslie Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Gottlieb Fritz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife H. Flora Fritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/96

8. AGE: Years	Months	Days	If less than one day
49	2	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Brewery

FATHER
12. Name Gottlieb Fritz
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Fritz
15. Birthplace Germany

16 (a) Informant Flora Fritz
(b) Address 21 Leslie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd

19 (a) APR 3 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Gretter M.D. Medical Examiner.
Date signed April 2 1945

G27522 over 93D G27522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4916 Ross Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4916 Ross Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. KOCH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Frederick Koch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
about 73			hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Erdman
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Frances Stubbins
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. L. E. Peters
(b) Address 4916 Ross Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr. 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lasselle Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date re...) (b) APR 3 1945 ...ington Hills, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st, 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1941, to Mar. 31 1945, and that I last saw h[illegible] alive on Mar. 31 1941.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	Over 5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Dawson, M.D.
Address 4808 Harford Rd Date signed 4/7/45

G27523

AB91701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G27523

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-11days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Upton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Hailstock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15- 1887

8. AGE: Years	Months	Days	If less than one day
58	2	16	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hailstock
13. Birthplace S.C.

MOTHER
14. Maiden Name Ellen Workman
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4-3-45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 (a) (Date rec'd by registrar) APR 3 1945 Huntington for Williams

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 31- 1945 at 10.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 1945 to 3-31- 1945
and that I last saw h in alive on 3-31- 1945

Immediate cause of death: Pulmonary tuberculosis — Duration: 0

Due to: Pulmonary tuberculosis — Duration: 0

Due to:

Other Conditions arteriosclerosis Ht. disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Labrand M. D.
Address Balto. City Hosp. Balto. Md. Date signed 4/1/45
X

G27524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G27524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rear - 1200 block N. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfonso McCarthy

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Adelein McCarthy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Alean McCarthy
(b) Address 225 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Owen L. Alford
(b) Address 927 N. Mont St.

19 (a) (Date received by registrar) APR 3 - 1945 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-1945, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Severed head at base of neck

Due to

Other Conditions Dismemberment of body
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-24-45 at P. M.
(b) Where did injury occur? 225 N. Calhoun Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home, While at work? No
(d) Means of injury Sharp instrument

23. Signature Thomas J. Riddick M.D.
Medical Examiner.
Date signed 3-26-45

VS 151

G27525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

G27525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Etting St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1905

8. AGE: Years 39 70 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. County (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Julia Saunders
15. Birthplace Md

16 (a) Informant Cornelius Wilson
(b) Address 1814 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 129 N. Caroline St.

APR 3 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 — 31 — 1945, at 1030 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945 to 3-31-1945; and that I last saw her alive on 3-31-1945.

Immediate cause of death | Duration

Bronchogenic Carcinoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E Wilson

Address 809 N Front Date signed 3-31-45 M. D.

G27526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706

Registered No. G27526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Mulliken St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mrs. Sarah Wallace

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Richard

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26, 1861

8. AGE: Years	Months	Days	If less than one day
83	11	5	..... hr. ..... min.

9. Birthplace Balt Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Cameriere

FATHER
12. Name William H. Wright
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Bernice Dixon
15. Birthplace Md.

16 (a) Informant Bernice Dixon
(b) Address 1708 Mulliken St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 '45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.
Location 9 A County Md

18 (a) Funeral director Mrs. Robert A. Elliott & Dyk
(b) Address 1629 N Carlton

19 (a) APR 3 - 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.F. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1945, at 9:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Fractured Pelvis

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-1-45 at 9:15 P.M.
(b) Where did injury occur? Orleans & Mulliken Sts between Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NA
(d) Means of injury Struck by Truck

23. Signature Thomas J. Williams M.D. Medical Examiner.
Date signed 4-2-45

G27527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G27527

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
Street No. 417 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Thomas R. Grant

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1907

8. AGE: Years	Months	Days	If less than one day
37	8	26	hr. min.

9. Birthplace Back River Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Owens Grant
13. Birthplace Arkansas

MOTHER
14. Maiden Name Frances Kendall
15. Birthplace Bee County Md.

16 (a) Informant Frances Grant
(b) Address 625 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Stephens Cem.
Location Back River

18 (a) Funeral director Mrs. Robert A. Elliott & Dept
(b) Address 1129 N. Carolina St

APR 3 - 1945 (Date rec'd by registrar) (by) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Examination - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lubinski M.D. Medical Examiner.
Date signed 4/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G27528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G27528

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1227 WALL ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 WALL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA. DORSEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED.

6 (b) Name of husband or wife JAMES C DORSEY
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) NOV 25-1908

8. AGE: Years	Months	Days	If less than one day
36	4	7	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business -

FATHER
12. Name LEO WM. GRAVES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARTHA ALVERTON
15. Birthplace MARYLAND

16 (a) Informant JAMES. C. DORSEY.
(b) Address 1227 WALL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-5-45 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location GLEN BURNIE MD

18 (a) Funeral director Bernard E Hanke
(b) Address 121 E West St

19 APR 3 - 1945 (Date received by Registrar) Huntington Williamsport MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 1st 1945, at 11 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944, to April 1 1945, and that I last saw h.m. alive on March 31 1945.

Immediate cause of death
Pulmonary Tuberculosis (advanced Last) — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Dr. A. J. Barranco
Address 436 E Lafayette Ave Date signed 4/3/45

X

G27529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

G27529 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE V. WISONG

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank A. Wisong

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1859

8. AGE: Years 86 | Months 0 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John H. Riall
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Kelly
15. Birthplace Md.

16 (a) Informant Mrs. Mary E. Hartje
(b) Address 5204 Wesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1945, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1945 to April 1 1945 and that I last saw h[illegible] alive on March 27 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	6 mos.
Due to Arteriosclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. W. Billings M. D.
Address 2224 N. North Ave. Date signed 4/3/45

G27530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V50

G27530 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 W. 26th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence A. Dix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry Dix

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1862

8. AGE: Years 82 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Clarence E. Sipes
(b) Address 415 W. 26th Street

17 (a) Burial (b) Date thereof April 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (Date received by registrar) APR 3 - 1945 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2, 1945, at 6 P.M.

21. I certify that I took charge of the remains described above, held an inquest and Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Left Breast

Due to

Other Conditions Fractured femur, Accident contributed
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury January 1945 at M.
(b) Where did injury occur? 415 W. 26th Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Stumbled on rug & fell.

23. Signature R. P. Lubinski M.D.
Medical Examiner.
Date signed 7/3/45

627531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1714

Registered No. 627531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5207 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter V. Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Lillian K. Setone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Md. Nut & Bolt Co.

FATHER
12. Name Wm P. Hammond
13. Birthplace Md

MOTHER
14. Maiden Name Annie Vansant
15. Birthplace Md

16 (a) Informant Mrs Lillian K Hammond
(b) Address Arnold Md

17 (a) Buried (b) Date thereof 4.4.45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Johnny H Whitaker
(b) Address 410 E Edmondson Ave

19 (a) APR 3 - 1945 (b) Huntingtown Prince Georges, Md
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 45, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound
Comminuted Fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27-14 45
(a) Date of injury March 31 1945 8 P M.
(b) Where did injury occur? St Charles & Belvedere Aves
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by street car

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 1 1945

G27532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27532
TN. 92632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 89B

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15- days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Jackson Square
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Kenneth Henninger

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 183-12-9185

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 10th. 1922

8. AGE: Years	Months	Days	If less than one day
22	10	22	..... hr. ..... min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Boiler shop
11. Industry or business Md. Drydock Co

FATHER
12. Name Henry Henninger
13. Birthplace Pa.

MOTHER
14. Maiden Name Nellie Scheetz
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 4 6 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory I.O.O.F. Cemetery
Location Shamokin Pa

18 (a) Funeral director Langham Funeral Home
(b) Address 7401 Belair Rd.

19 (a) ..... (Registrar) (b) Huntington Williams M.D.

APR 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1945 19 ..... at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 19 45 to April 2 19 45
and that I last saw h im alive on 4-2-45 19 .....

Immediate cause of death Rupture of Brain aneurism

Due to Chronic Nephritis

Due to .....

Other Conditions Lateral sinus thrombosis Appendicitis

(Include pregnancy within 3 months of death)

Date of operation 3-21-45 3-24-45 3-25-45

Major findings of operation Same

of autopsy .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature H Butler M. D.
Address City Hosp Date signed 4-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27533 / 55 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo20da
(e) Length of stay in Baltimore (yrs., mos., or days) 2mo20da

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town Bayonne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 64 W. 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Edward Van Scriver

3 (b) If veteran, name war

3 (c) Social Security Account No. 138-07-2414

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Parrish
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1908

8. AGE: Years	Months	Days	If less than one day
36	4	15	hr. min.

9. Birthplace Camden, New Jersey
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Edward Van Scriver
13. Birthplace New Jersey

MOTHER
14. Maiden Name May Howlings
15. Birthplace New Jersey

16 (a) Informant Mrs. Elizabeth P. Van Scriver
(b) Address 64 W. 25th St. Bayonne N.J.

17 (a) Burial (b) Date thereof 4-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Bayonne N.J.

18 (a) Funeral director A. Lee Elder
(b) Address 4647 York Rd. Huntington Station, Md.

19 (a) APR 3 1945 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945, at 10:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11, 1945, to Mar. 31 1945 and that I last saw him alive on Mar. 31, 1945.

Immediate cause of death: Sarcoma left hip region with massive metastasis in both lungs and pleural cavity — Duration 4 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a). Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joan I. Jakeman
Address US Marine Hospital, Baltimore, Maryland Date signed 5/1/45

J. F. VANACKEREN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G27534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town R.D. 9 Baltimore, Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Douglas Squirrel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1944

8. AGE: Years 0 | Months 10 | Days 4/24 | If less than one day hr. min.

9. Birthplace Near Westminster Carroll Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Corrine Squirrell
15. Birthplace Carroll Co. Md.

16 (a) Informant Corrine Squirrell
(b) Address Baltimore RD 9. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 4/45 (month) (day) (year)
(c) Cemetery or crematory Western Chapel Cem.
Location Near Westminster Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster Md.

19 (a) APR 3 — 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945 to 4/3 1945, and that I last saw h[illegible] alive on 4/3 1945.

Immediate cause of death: Tuberculous meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell, M.D.
Address Provident Hospital Date signed 4/3/45

X

G27535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G27535 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954-Forrest St
(c) Hospital or institution: Maryland Penitentiary Bookslab
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 Rusk Ave (If rural give location) Rusk
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Paul Lawrence Allen

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mildred Allen
6 (c) If alive, give age ?? years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1914

8. AGE: Years 31 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Frederick County, Md. (Town, county, and state)

10. Usual Occupation Iron worker

11. Industry or business

FATHER
12. Name Marshall Allen
13. Birthplace Richmond, Va

MOTHER
14. Maiden Name Cora Wilkerson
15. Birthplace New Jersey

16 (a) Informant Mildred Allen
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Frederick Md
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) 4-1945 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1945, at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to April 3 1945, and that I last saw him alive on April 3 1945.

Immediate cause of death: Tuberculous peritonitis — Duration

Due to: Intestinal tuberculosis

Due to: and pulmonary tbc.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. F. Harris. M. D.
Address Md. Penitentiary Hosp. Date signed 4-3-45

G27536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G27536

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 W. Fall Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN B. MADDEN

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Richard Madden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1901

8. AGE: Years 43 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Mansfield Betz
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Jane Dougherty
15. Birthplace Maryland

16 (a) Informant Richard Madden
(b) Address 1735 W. Fall St.

17 (a) Burial (b) Date thereof 4-4-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address Frederick Avenue

19 (a) APR 4 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1945, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1945 to 4-1 1945; and that I last saw her alive on 4-1 1945

Immediate cause of death CARDIAC AND RESPIRATORY FAILURE — Duration

Due to PULMONARY EMBOLISM

Due to

Other Conditions CARCINOMA OF RECTO-VAGINAL SEPTUM
(Include pregnancy within 3 months of death)

Date of operation 3-22-45

Major findings of operation: SAME.

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Norment III M.D.
Address Univ. Hosp. Date signed 4-1-45
M. D.

VS 150

X

G27537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G27537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St.
(c) Hospital or institution West. Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Alabama Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Gloria Jean Breitenbach (Breitenbach)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1942

8. AGE: Years	Months	Days	If less than one day
2	3	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles L. Breitenbach
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Maryland

16 (a) Informant Mrs. Charles Breitenbach
(b) Address 2904 Alabama Ave. Balto County, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cemetery
Location Howard County, Md.

18 (a) Funeral director Leon. E. Ward
(b) Address 710 Frederick Ave.

19 (a) APR 4 - 1945 Huntington, W. Va. (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/45 19 , at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/45 19 to 4/1/45 19 , and that I last saw h alive on 4/1/45 19

Immediate cause of death Diffused Peritonitis — Duration

Due to Ruptured Appendix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/1/45

Major findings of operation: Ruptured Appendix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Dowkan

Address Wst Balto Gen Hospital Date signed 4/1/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

G27538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. G27538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Adella
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LURA STOUT SWITZER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Clarence R. Stout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	6 5	hr. min.

9. Birthplace Waterloo, Iowa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jonathan Stout
13. Birthplace ?

MOTHER
14. Maiden Name Harriet Carter
15. Birthplace ?

16 (a) Informant Mrs. Lucille Embshoff
(b) Address Adella, Pennsylvania

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 7 1945 (month) (day) (year)
(c) Cemetery or crematory Statesville.
Location Delta Pa

18 (a) Funeral director Hubert P Hankins.
(b) Address Delta, Pa.

APR 4 - 1945 (Date rec'd by Registrar) Huntington Williams M.D. (Name of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945, at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945, to April 4 1945, and that I last saw h.er alive on April 4 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other Conditions Pneumonia, lobar (bilateral) and post-operative convalescence	

(Include pregnancy within 3 months of death)
Date of operation April 1, 1945
Major findings of operation: Strangulated femoral hernia, left
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John O. Morris, M.D.
Address Delta. Date signed 4-4-45

VS 150

G27539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G27539

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County.....
(c) City or town Emmer
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bradley McCoury

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11/1914

8. AGE: Years 29 | Months 8 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Andrew McCoury
13. Birthplace N.C

MOTHER
14. Maiden Name Trusie Unknown
15. Birthplace N.C.

16 (a) Informant Chas Buchanan
(b) Address 2907 Garnet Ave

17 (a) Burial (b) Date thereof 4/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loving Heart
Location Glenwood Hills

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 402 E. Wolfe St.

19 (a) APR 4 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1945, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found Dead at 1st 1945 3/2 9 A.M.
(b) Where did injury occur? Harbor foot of Fleet St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Found Drowned

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 3 1945

VS 151

G27540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27540

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 S. BAYLIS ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 S. BAYLIS ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY L. DAMBROSIA

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: CARMINO DAMBROSIA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 1 1881

8. AGE: Years 63 | Months 3 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace ITALY
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ITALY

16 (a) Informant MRS. LUBEN (DAUGHTER)
(b) Address 906 S. BAYLIS ST.

17 (a) BURIAL (b) Date thereof APR. 4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 APR 4 - 1945 (b) Huntington Williams MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 31 1945, at 9.30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1954, to March 31 1945, and that I last saw him alive on March 31 1945

	Duration
Immediate cause of death: Acute cardiac dilatation	20 min
Due to: Chr. myocarditis	1937
Due to: Hypertension cardio vascular renal disease	1937
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. A. Alessi M. D.
Address 6217 Harford Rd Date signed 4/2/45

VS 150

G27541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

G27541 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 E 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY UMPHREYS (UMPHRIES)

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 15th 1872

8. AGE: Years 72 | Months 11 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Plasterer

FATHER
12. Name James H. Umphreys
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Kate E. Vandersmith
15. Birthplace Balto. Co. Md.

16 (a) Informant Kate E. Magarity
(b) Address 512 E. 22nd St.

17 (a) Burial (b) Date thereof 4/5/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Asbury M.E.
Location Reisterstown Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 4-5-1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis; Compound comminuted fracture of leg, left

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/4

(a) Date of injury 4-2-45 at 1:30 A. M.
(b) Where did injury occur? North Avenue & Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto.

23. Signature Robert L. Traitzen M.D.
Medical Examiner.
Date signed April 3 1945

G27542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G27542 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Bentalou Place.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Frank Fremont Peard.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mrs. Nancy Peard
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) March 5, 1899
8. AGE: Years 46 Months 00 Days 29 If less than one day 11 hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Banker.
11. Industry or business

FATHER
12. Name Mr Frank F Peard
13. Birthplace Canada

MOTHER
14. Maiden Name Sidney Price
15. Birthplace Maryland.

16 (a) Informant Nancy Wheeler Peard
(b) Address 700 Bentalou Place

17 (a) Burial (b) Date thereof Feb 6 '45
(Burial, cremation, or removal) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville Md.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Date rec'd by Registrar APR 4 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3/1945 at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944 to 4/3 1945 and that I last saw h.. alive on 4/3/45

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Cerebral Hemorrhage.	2 hrs.
Due to Essential Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/2/44 & 12/7/44 Tubectomy
Major findings of operation: Thrombo-Lumbar sympathectomy
of autopsy: was done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins Jr. M. D.
Address Union Memorial Date signed 4/3/45

X

G27543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G27543

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 229 East 33rd St
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. H[redacted] Harlan (Ariel F.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Herbert H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1905

8. AGE: Years	Months	Days	If less than one day
39	3	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Reg. Nurse

11. Industry or business

FATHER

12. Name Mr. Richard H. Webster

13. Birthplace Maryland

MOTHER

14. Maiden Name Harriet A. Williams

15. Birthplace Maryland

16 (a) Informant Mrs. Webster

(b) Address 5 Upland Road

17 (a) Burial (b) Date thereof April 4 '45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Presbyterian Cemetery

Location Churchville, Md

18 (a) Funeral director Dean & Foster

(b) Address Bel Air Md

19 (a) APR 4 1945 Huntington Williamsport, Md
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945, at 8:50P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1945 to April 2 1945, and that I last saw her alive on April 2 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Staphylococcus Septicemia	
Due to Staphylococcus Pneumania	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Alfred C Hutchinson M. D.

Address 208 E. 34th St Date signed 4-2-45

632 Franklin
G27544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

✓ G27544
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 590 St. Mary Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 590 St. Mary St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no.

3 (a) FULL NAME Walter Thomas Johnson (Jr.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1945

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Baby.
11. Industry or business

FATHER
12. Name Walter Thomas Johnson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Bush
15. Birthplace Norfolk, Virginia

16 (a) Informant Mark Johnson
(b) Address 590 St Mary St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Signature of city registrar) (b) Hunting Town Maryland, Md.

APR 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945 to 4/2 1945; and that I last saw him alive on 4/2 1945.

Immediate cause of death Traumatism at birth. — Duration 10 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Stewart M. D.
Address 632 Franklin Date signed 4/4/45

G27545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27545 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 George St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Brown

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Black

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-29-82

8. AGE: Years 32 | Months — | Days 4 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Beulah Byrd.
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-5-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Pennsylvania Ave

19 (a) (Date received by Registrar) MAR 6 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2-1945 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13-1945 to 4-2-1945, and that I last saw h[illegible] alive on 4-2-1945

Immediate cause of death: Uremia

Due to arteriolonephrosclerosis

Due to

Other Conditions Hypertension cardiovascular disease

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Graham A. Vance M.D.

Address Johns Hopkins Hosp. Date signed 4/3

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27546

JO #91651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G27546 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joe Rivers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Tiney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1895

8. AGE: Years	Months	Days	If less than one day
50	-1-	11	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Cornelius
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ella Otes or Ates
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Shreve St

19 (a) APR 4 - 1945 (Date received by Registrar) Katie Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18, 1945, to Mar. 31, 1945, and that I last saw h im alive on Mar. 30, 1945.

Immediate cause of death	Duration
Pulmonary hemorrhage	minutes
Due to Pulmonary tuberculosis	7 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luis Lazaro
Address Balto. City Hosp. Balto. Md. Date signed M. 3/31/45 D.

G27547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B ✓ Registered No. G27547

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Normandy Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Normandy Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE A. KIRBY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business G. Fred Kranz Co.

FATHER
12. Name Benjamin F. Kirby
13. Birthplace Wye Mills, Md.

MOTHER
14. Maiden Name Mary E. Theban
15. Birthplace Balto., Md.

16 (a) Informant Miss Maryland Kirby
(b) Address 512 Normandy Ave.

17 (a) Burial (b) Date thereof 4/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

APR 4 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945, at 10:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1943 to 4/2 1945 and that I last saw h 25 alive on 4/2 1945

Immediate cause of death	Duration
Pulmonary edema	15 mins
Due to Coronary occlusion	1 wk ?
Due to Rheumatic heart disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reite, M.D.
Address 340 Court Square Bldg Date signed 4/4/45

G27548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2716 St. Paul
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 St Paul.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEANNETTE EVA McDANNEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm. McDannel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1882

8. AGE: Years 62 | Months 5 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel K. P. Downey

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Ella Hamburger

15. Birthplace Va.

16 (a) Informant Mrs. William H. Bloxom Jr.

(b) Address 3807 Granada Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/6/45 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location Baltimore, Maryland

18 (a) Funeral director William J. Dukes & Son

(b) Address North & Pennsylvania Ave

19 APR 4 - 1945 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1945, at 4.30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

(e) Signature Joseph B. McNally M.D. Medical Examiner.

Date signed 4/5/45

VS 151

G27549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G27549

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st.St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 E.Clements St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Morman Sadler

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-07-9587

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mamie Rainier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1883

8. AGE: Years	Months	Days	If less than one day
61	9	1	hr. min.

9. Birthplace Wake, Va.
(Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafaring

FATHER
12. Name James A. Sadler
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Dunlavy
15. Birthplace Virginia

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Rem. (B) (Burial, cremation, or removal) (b) Date thereof 4 - 6 - 45 (month) (day) (year)
(c) Cemetery or crematory Hemming Woods.
Location Middlesex County, Va
18 (a) Funeral director James L. McCauley
(b) Address P.O. Box Tappahannock, Va

APR 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945 at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 28 1945, to April 3 1945, and that I last saw him alive on April 3 1945

Immediate cause of death	Duration
Cerebral hemorrhage	6 days
Due to Hypertensive Cardio-vascular disease	Unk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Mayer C.A.P. M. D.
Address US MARINE HOSPITAL Date signed 4/3/45
Baltimore, Md.

G27550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27550 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walkers + Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Grace Dushane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-1872

8. AGE: Years 73 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Retired Saleslady

11. Industry or business

FATHER
12. Name James A. Dushane
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Elizabeth J. Ward
15. Birthplace Ireland

16 (a) Informant Mary Dushane
(b) Address 15 N. Fulton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Bernard, Huntington Ave. Balto. Md.

19 (a) (Date rec'd by registrar) APR 4 - 1945 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1945 to 4-2 1945 and that I last saw her alive on 4-2 1945

Immediate cause of death Cerebral Hemorrhage

Due to Hypostatic pneumonia

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Raiford Jr. M.D.
Date signed 4/5/45

X

C27551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. C27551

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write out the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Payson Ave & Dukeland St

(c) Hospital or institution West Balto. Gen. Hosp W 15 minutes

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 204 S. Eutaw St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME F. Henry Stevenson

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of ~~husband or~~ wife Lillian

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Apr 13 1917

8. AGE: Years	Months	Days	If less than one day
27 29	11	17	hr. min.

9. Birthplace Galt Md (Town, county, and state)

10. Usual Occupation Copper smelter

11. Industry or business Self.

FATHER 12. Name Henry Stevenson

FATHER 13. Birthplace Russia.

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace unknown.

16 (a) Informant F. Henry Stevenson Jr.

(b) Address 204 S. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Frederick, Md.

18 (a) Funeral director Charles W. Kuchenbecker

(b) Address 703 McHenry St.

19 (a) APR 4 — 1945 (b) Huntington Williams, M.D.

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1945, at 9:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945 to 3/30 1945 and that I last saw h[illegible] alive on 3/30 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Leukemia	
Due to (Original in N.Y.C.)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irving J. Taylor M. D.

Address WBCM Date signed 3/30/45

VS 150

G27552
CWK-92567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G27552
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68- 2- 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Dombrowski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16-1877

8. AGE: Years 68 | Months 2 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael Dombrowski, (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Lintz, (D)
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St. Huntington Station, L.I.

19 APR 4 - 1945 (Date rec'd by Registrar)
(b) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 1 1945, at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1945, to April 1 1945, and that I last saw h im alive on April 1 1945

Immediate cause of death: Myocardial failure — Duration: 2 wks.
Due to: Arteriosclerotic heart disease — ?
Due to:
Other Conditions: Splenic & renal infarcts Mitral Insufficiency. Emphysema — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Sense.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 4-2-45

VS 150

G27553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27553 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Druid Hill Ave.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Druid Hill A ve.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Strott

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ August A. Strott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	27	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Confectionery Store
11. Industry or business

FATHER
12. Name Kunigunda Hupfar
13. Birthplace Germany

MOTHER
14. Maiden Name Johann Hupfer
15. Birthplace Germany

16 (a) Informant Mr. Gustav A. Strott
(b) Address 1014 Druid Hill Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) APR 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 25. 1945, to Apl 2 1945, and that I last saw her alive on Apl. 2. 1945.

Immediate cause of death: Acute Cardiac Dilatation — Duration 2 hrs

Due to: Chr. Myocarditis — 2 yrs

Other Conditions: old age.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Hy Lyt. C. Blake M. D.
Address Med. Arts Bldg Date signed

VS 150

X

G27554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1945

G27554
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1939 W. Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 W. Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Elizabeth Lorentz

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widowed

6 (b) Name of husband or wife Jacob Lorentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8. 1871

8. AGE: Years	Months	Days	If less than one day
74	1	25	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name August Willeke
13. Birthplace Germany

MOTHER
14. Maiden Name Catharine Leimper
15. Birthplace Germany

16 (a) Informant Mrs. Clare C. Wheeley
(b) Address 1939 W. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) APR 4 (Date rec'd by registrar) (b) 1945 Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1. 1945, at 11.50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945, to April 2 1945, and that I last saw him alive on 3.31. 1945

Immediate cause of death	Duration
Hemorrhage from Esophageal Diverticula	Sudden
Due to —	
Due to —	
Other conditions Hypotension Contributed Heart disease	Long

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1901 Eutaw Pl. Date signed 4/5/45

VS 150

116

G27555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27555
Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Faulkner
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bohanon, Columbus Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5- 1893

8. AGE: Years	Months	Days	If less than one day
51	6	27	hr. min.

9. Birthplace Va.
(Town, county and state)

10. Usual Occupation Rural Route.

11. Industry or business

FATHER
12. Name Columbus III Bohanna
13. Birthplace Va

MOTHER
14. Maiden Name Mary V. Bohanna
15. Birthplace Fredericksburg Va

16 (a) Informant Blanche Hozier
(b) Address Norfolk Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 6/45 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Va
Location Virginia

18 (a) Funeral director Williams Funeral Home
(b) Address 1217 St Paul St

19 (a) [illegible] (b) Huntington Williams Jr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1945, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945 to 4-2 1945 and that I last saw h[illegible] alive on 4-2 1945

Immediate cause of death Pulmonary Edema — Duration

Due to Malignant Hypertension

Due to Pneumonia Secondary Congestive Heart Failure.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Gourley M.D.

Address Christ Hosp. Date signed 4/5/45 M.D.

X

G27556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 W. Cross Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 W. Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Keth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lenora W. Keth
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) April 13, 1897

8. AGE: Years	Months	Days	If less than one day
47	11	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Dock master
11. Industry or business U. S. C. G.

FATHER
12. Name Peter H. Keth
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie C. Higdon
15. Birthplace Maryland

16 (a) Informant Davis L. Jump
(b) Address 3129 Hearth Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 6-1945 (month) (day) (year)
(c) Cemetery or crematory Bates National City
Location

18 (a) Funeral director Roth & B. M. Walter
(b) Address Bath & Stricker Sts

19 (a) APR 4 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945, at 11:50 P M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Varicose veins lower extremities
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Mc Nally Jr. Medical Examiner.
Date signed April 4, 1945.

G27557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G27557
Registered No.

MARGIN RESERVED FOR HANDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 S. CARLTON Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIET G. BRITTINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Algie K.
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) March 11, 1906

8. AGE: Years	Months	Days	If less than one day
39	0	22	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robt. Smith
13. Birthplace Delaware

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Algie K. Brittingham
(b) Address 29 S. Carlton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5-1945 (month) (day) (year)
(c) Cemetery or crematory Lauton Park
Location City

18 (a) Funeral director Roff & B. M. Walters
(b) Address Pratt & Hickes Sts

19 (a) APR 4 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 2 1945 5 P.M.
(b) Where did injury occur? 29 S Carrollton St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed April 3 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627558

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 479

627558 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st. St.
(c) Hospital or institution:
U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.3d.
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Kentucky (b) County
(c) City or town Louisville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Montgomery St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Partain, James Claude

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nora M. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1900

8. AGE: Years	Months	Days	If less than one day
44	11	16	hr. min.

9. Birthplace Elberton, Ga.
(Town, county, and state)
10. Usual Occupation Laundry Worker, US Marine
11. Industry or business Hospital, Louisville, Ky.PHS

FATHER
12. Name Wm. Partain
13. Birthplace

MOTHER
14. Maiden Name Mary Doyle
15. Birthplace

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7, 45 (month) (day) (year)
(c) Cemetery or crematory
Location Louisville Ky.

18 (a) Funeral director A. Lee Edyl
(b) Address 4644 York Road

19 (a) (Date received by registrar) APR 4 1945 (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945, to April 4 1945, and that I last saw him alive on April 4 1945.

Immediate cause of death: Carcinoma of the lung — Duration: 4 mos.
Due to
Due to
Other Conditions: Syphilis of undiagnosed site — over
(Include pregnancy within 3 months of death)
Date of operation 3/27/45
Major findings of operation: Thoracotomy, exploratory
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Jr. [illegible] Ackeren
Address US Marine hospital Baltimore, Md. Date signed 4/4/45

G27559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE NO MARKS IN SPACE RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Prospect Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGH G EATON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ida J.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	10	____hr. ____min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Genl Manager
11. Industry or business Becontalls Rubber Co

FATHER
12. Name Lloyd Eaton
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Nellie Cook
15. Birthplace

16 (a) Informant Funeral Director
(b) Address 1066 Lexington Ave N.Y.

17 (a) Burial (b) Date thereof April 7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Lawn
Location Keene N.H.

18 (a) Funeral director A. Lee Odell
(b) Address 4644 York Road

19 (a) APR 4 1945 (b) [illegible]
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1945 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weston M.D.
Medical Examiner
Date signed 4/3/45

G27560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27560 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 Eastern Aveneu
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Saul

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Conrad Saul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/78

8. AGE: Years 67 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business at home

FATHER
12. Name George Raugh
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Conrad Saul, (Hus)
(b) Address 2425 Eastern Avenue

17 (a) BURIAL (b) Date thereof APR. 5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. MATTHEW
Location ODONNELL ST.

18 (a) Funeral director Lilly & Geiler Bros
(b) 405 South Wolfe Street

APR 4 1945
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1945, at 8 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1943 to April 2 1945
and that I last saw h[illegible] alive on April 1 1945

Immediate cause of death: Chronic Myocarditis — Duration 2 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Milton L. Solomon
Address 129 S Broadway Date signed 4/4/45

G27561 BALTIMORE CITY HEALTH DEPARTMENT G27561
CERTIFICATE OF DEATH 108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1657 Thomas Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1657 Thomas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME REBECCA RODGERS WILKINS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benj. N. S. Wilkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1853

8. AGE: Years: 92 | Months: 2 | Days: 6 7 | If less than one day: hr. min.

9. Birthplace: Chestertown, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Gray
13. Birthplace: New Castle, Del.

MOTHER
14. Maiden Name: Margaret Anderson
15. Birthplace: Chestertown, Md.

16 (a) Informant: Mr. Paul Wilkins
(b) Address: 2822 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)
(c) Cemetery or crematory: Chester Cem.
Location: Chestertown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 4-5-1945 (c) Filed by registrar: Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH: April 3, 1945, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Apr 3 1945, and that I last saw h-er alive on Apr 3 1945.

Immediate cause of death: Lobar Pneumonia — Duration: 2 days
Due to:
Due to: myocarditis, Gen'l Arterio Sclerosis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy: none-deaf

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Edwin A. Rutland, M.D.
Address: 2219 Gaylord Street Date signed 4/4/45

VS 150

G27562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27562 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 Scott St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Scott St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert A. Hawkins

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Margaret Hawkins
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): June 6, 1866
8. AGE: Years 78 | Months 9 | Days 27 | If less than one day — min.
9. Birthplace: A.A. Co. Md. (Town, county, and state)
10. Usual Occupation: retired salesman
11. Industry or business: —

FATHER
12. Name: William Hawkins
13. Birthplace: England

MOTHER
14. Maiden Name: Not Known
15. Birthplace: " "

16 (a) Informant: Wm Hawkins
(b) Address: 703 Scott St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/5/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Ave
18 (a) Funeral director: Geo Leimbach
(b) Address: 25 N. Lyndhurst St.
(a) Date received: APR 4 1945 (b) (Registrar) Huntington Wilkinson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945 at 8:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1945 to Apr. 2 1945, and that I last saw him alive on Apr. 1st 1945.

	Duration
Immediate cause of death: coronary thrombosis	5 Min.
Due to: arteriosclerotic cardio vascular disease	3 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Geo. F. Kemp
Address 3030 Edmondson Ave Date signed 4/2/45

G27563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G27563 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3302 Norman Ave.
(c) Hospital or institution: ----------

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Norman Ave. (If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Henry Anthony Brehm

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Julia E. Gittere
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) April 17, 1867

8. AGE: Years	Months	Days	If less than one day
77	11	16	-- hr. -- min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business ----------

FATHER
12. Name George Brehm
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Winter
15. Birthplace Germany

16 (a) Informant Gertrude B. Goldbach
(b) Address 212 Stratford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery ###### Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. V. Mears & Son
(b) Address 805 N. Calvert St.

19 APR 5 1945 (b) Huntington Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1945, to 4-3 1945, and that I last saw h--- alive on 4-1 1945

Immediate cause of death	Duration
Heart failure	
Myocardial insuff-	
Ischemia	
Due to Cerebral Hemorrhage -	
Senility - Arterio - sclerosis	
Diabetes mellitus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Lagges M. D.
Address 700 Cathedral Date signed 4-4-45

X

Dr. Harding
3914 Belair Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27564

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4501 Valley View Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 Valley View Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis J. Straney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1880

8. AGE: Years	Months	Days	If less than one day
64	7	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Helper on Truck
11. Industry or business American Railway Exp.

FATHER
12. Name Edward W. Straney
13. Birthplace Kentucky

MOTHER
14. Maiden Name Elizabeth Brown
15. Birthplace Maryland

16 (a) Informant Mrs. Matilda Straney
(b) Address 4501 Valley View Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

APR 5 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to April 2 1945 and that I last saw h.m alive on 3/30 1946

Immediate cause of death	Duration
ac Dilatation Heart	
Due to Ch. Myocarditis arter. Sclerosis	1 yr.
Due to	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. S. Harding M. D.
Address 4510 Belair Rd Date signed 4/7/45

X

G27565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No. G27565

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Wilcox st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Parr

3 (b) If veteran, name war (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Anna Mc Bride
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21st 1888

8. AGE: Years	Months	Days	If less than one day
56	6	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Self

FATHER
12. Name Conrad Parr
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine Bush
15. Birthplace Germany

16 (a) Informant Catherine Bennett
(b) Address 1403 Enon st

17 (a) Burial (b) Date thereof 4/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st

19 (a) (Date rec'd by registrar) Registrar

APR 5 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1945 to 4/3 1945, and that I last saw h[illegible] alive on 4/2 1945.

Immediate cause of death	Duration
Cardio Resp Failure	
Due to Generalized Arteriosclerosis	
Due to Perforated Duodenal Ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Simmons M. D.
Address Sinai Hospital Date signed 4/3/45

X

G27566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G27566

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga Ave & Oakland St.
(c) Hospital or institution: West. Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Vandegrift

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband: Ernest Vandegrift
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28th 1880

8. AGE: Years: 64 | Months: 10 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: at Home

FATHER
12. Name: Thomas Ryan
13. Birthplace: Unknown

MOTHER
14. Maiden Name: (Unknown) Shook
15. Birthplace: "

16 (a) Informant: Ernest Vandegrift
(b) Address: 828 W. Lombard St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof: 4/6/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: St. Peters
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/3/45 19, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22/45 19 to 4/3/45 19, and that I last saw h[illegible] alive on 4/3/45 19.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Myocardial Infarction	
Due to	
Other Conditions R. Inguinal Hernia (Include pregnancy within 3 months of death)	

Date of operation 1/26/45
Major findings of operation: R Inguinal Hernia Strangulated
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James A. Durkan M. D.
Address West Balto Gen Hospital Date signed 4/5/45

vs 1b APR 5 1945 Huntington Williams, M.D.

C27567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

C27567 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Lena P Siegmund

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Female — 5. Color or race White — 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Nelson A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edmond Shuppel

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Kepnick

15. Birthplace Md

16 (a) Informant E A Siegmund

(b) Address 1111 Guilford Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilson Conley

(b) Address 1217 N Eutaw St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 5 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at 2 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1944 to 4-5 1945 and that I last saw h alive on 4-3 1945.

	Duration
Immediate cause of death Gastro intestinal infection + hypostatic pneumonia *	10 days
Due to Dia betes * + decubitus ulcers -	2 mo
Due to phlebitis of left leg - + asl -	6 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. E. Siegmund M. D.

Address Medical Arts Bldg Date signed 4/4/45

X

B 27568. BALTIMORE CITY HEALTH DEPARTMENT E-27568
94a Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 Hawthorne Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Hawthorne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: DR. HERMAN LOUIS EBELING

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma Stakeman Ebeling
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 10, 1856
8. AGE: Years 88 | Months 10 | Days 22 | If less than one day hr. min.
9. Birthplace: Catonsville, Md. (Town, county, and state)
10. Usual Occupation: Professor of Greek
11. Industry or business: Emeritus - 14 yrs.

FATHER
12. Name: Wilhelm Ebeling
13. Birthplace: Germany

MOTHER
14. Maiden Name: Marie Apfel
15. Birthplace: Germany

16 (a) Informant: Mrs. Emma S. Ebeling
(b) Address: 329 Hawthorne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

APR 5 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from See notes on back 19, and that I last saw him alive on Apr. 2 - 1945.

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Arteriosclerosis (Senile)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Hunter B. E. Deegan M. D.
Address: 2 W. Read Date signed

X

G27569
JO #92473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G27569
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fedderman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1869

8. AGE: Years	Months	Days	If less than one day
76	-0-	-3-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unable to obtain information
11. Industry or business

FATHER
12. Name Job Fedderman
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mr. Francis A. Hemsley
(b) Address 576 W. Biddle St.

19 (a) APR 5 1945 Huntington Williams M.D.
(Registrar) (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945 at 9:23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 8, 1945, to April 2, 1945, and that I last saw him alive on Apr. 2, 1945.

Immediate cause of death	Duration
Uremia & Hypostatic pneumonia	
Due to Ca of Stomach & Metastases	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-2-45
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Leuten M. D.
Address City Hosp Date signed 4-3-45

G27570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G27570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 E. Preston Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROL WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Johnnie Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1926

8. AGE: Years	Months	Days	If less than one day
19	5	27	hr. min.

9. Birthplace Chicago, Illinois (Town, county, and state)

10. Usual Occupation

11. Industry or business Western Electric

FATHER 12. Name Richard Montgomery
13. Birthplace Mississippi

MOTHER 14. Maiden Name Edna Distance
15. Birthplace Balto., Md.

16 (a) Informant Richard Montgomery
(b) Address 1117 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. G. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1364 N. Central Ave

19 APR 5 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1945, at 2:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Chronic Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 3rd 1945

G27571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G27571

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2542 Mc. Henry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2542 Mc. Henry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NOLA - P. KERN.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Charles E. KERN.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1898.

8. AGE: Years	Months	Days	If less than one day
46	5	23	hr. min.

9. Birthplace Martinsville - Ill.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business at home.

FATHER
12. Name Henry Buckner.
13. Birthplace Ill.

MOTHER
14. Maiden Name Malissa McDonald.
15. Birthplace Ill.

16 (a) Informant Mrs. Charles E. Kern.
(b) Address 2542 McHenry St.

17 (a) Burial. (b) Date of (Burial, cremation, or removal) April 6-45.
(month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

APR 5 1945 (Date received by Registrar) (Signature of Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 3rd. 1945 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1943 to 4/3 1945, and that I last saw her alive on 4/3 1945

Immediate cause of death	Duration
Carcinomatosis	(?).
Due to Angina de (Beriberi?)	2yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Bogrod
Address 1905 W. Baltimore Date signed 4/5/45 M.D.

X

27572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G27572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Horace Love

3 (b) If veteran, name war

3 (c) Social Security Account No. 237-20-6012

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lizzie

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 24 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Ship Yards

FATHER
12. Name Sam Love
13. Birthplace North Carolina

MOTHER
14. Maiden Name Gertrude Gaddis
15. Birthplace North Carolina

16 (a) Informant Charlie Love
(b) Address 312 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-45 (month) (day) (year)
(c) Cemetery or crematory
Location Lumberton N.C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

APR 5 1945 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1945, at 8 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of the heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-1-45 at 5:30 P M.
(b) Where did injury occur? Saratoga St nr Gay St.
(c) Did injury occur at home, on farm, industrial place, or public place? Public While at work? no
(d) Means of injury Homicide Stabbing

23. Signature Howard J. Wolfe M.D. Medical Examiner.
Date signed April 4 1945

G27573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G27573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Brune Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HOPE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife –

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Gloster County, Virginia (Town, county, and state)

10. Usual Occupation Jobbing Work

11. Industry or business

FATHER 12. Name Robert Hope

13. Birthplace Hampton, Virginia

MOTHER 14. Maiden Name Martha Howard

15. Birthplace Gloster County, Virginia

16 (a) Informant Annie Hughes

(b) Address 700 Brune Street

17 (a) Burial (b) Date thereof 4-7-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Hahn

(b) Address 978 Druid Hill

19 (a) (b) Huntingtown, Md.
(Date rec'd by registrar)

APR 5 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945, at 8:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed April 9 1945

X

G27574 RUSSUM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27574 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Oldham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Oldham (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Russum

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine Russum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles Russum
13. Birthplace Dorchester Co. Md.

MOTHER 14. Maiden Name Elizabeth Hall
15. Birthplace Dorchester Co. Md.

16 (c) Informant Catherine Russum
(b) Address 1108 Oldham

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklyn Md

18 (a) Funeral director Thos O. Wilson
(b) Address 1 [illegible] Bentley ave

19 (a) APR 5 1945 (Date received by registrar) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to Apr 3 1945 and that I last saw h[illegible] alive on Apr. 3 1945

Immediate cause of death	Duration
Pulmonary edema	2 days
Due to Acute Myocarditis	1 day
Due to Hypostatic Pneumonia	5 days
Due to Cardio-vascular Heart Disease	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lerry M. D.
Address 1420 E. Chase Date signed Apr 4 '45

VS 150

G27575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30D

G27575
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Mount St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Levy Conquest

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Lela Mae
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 7-23-03

8. AGE: Years	Months	Days	If less than one day
41	8	11	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Freddie Conquest
13. Birthplace Virginia

MOTHER
14. Maiden Name Abell Wiley
15. Birthplace Virginia

16 (a) Informant Pendula
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location.....

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brattley Ave, Arlington, Virginia

19 (a).....(Date rec'd by registrar) (b).....Registrar

APR 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1945, to April 3 1945, and that I last saw h[illegible] alive on April 3 1945.

Immediate cause of death Hemorrhage? | Duration

Due to Rupture of aneurysm?

Due to Cardio-vascular Syphilis

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation April 3, 1945

Major findings of operation: Aneurysm of innominate artery

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Richard F. Whitehurst M.D.
Address [illegible] Date signed 4-3-45

G27576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G27576

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5920 Sefton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5920 Sefton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Mackenroth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Adolph G. Mackenroth
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 26, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	7	hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ? Hupfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Jung
15. Birthplace Germany

16 (a) Informant Mrs. Frieda Bratzel
(b) Address 5920 Sefton Ave. Balto 14 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Leyden Pk
Location Balto City

18 (a) Funeral director A. Bond & Sons
(b) Address 14 W. Lt. Harbor St

19 (a) 1945 (Date filed by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1945 at 9:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1, 1945 to April 3 1945 and that I last saw her alive on April 3 1945

Immediate cause of death Bronchio Pneumonia — Duration
Due to Senility
Due to
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 3001 Shannon Drive Date signed 4/4/45

G27577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3902 Overlea Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3902 Overlea Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? N years

3 (a) **FULL NAME** Dr. H. Lee Franks

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: SENATOR E. Franks

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1867

8. AGE: Years 77 | Months 7 | Days 29 | If less than one day: hr. min.

9. Birthplace Fairview Marion Co W Va (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER — 12. Name Legge K Franks

13. Birthplace Waynesburg Greene Co Pa

MOTHER — 14. Maiden Name Fannie Golden

15. Birthplace Waynesburg Greene Co Pa

16 (a) Informant Lloyd E. Franks

(b) Address 3902 Overlea Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Edmonston Hyattsville Md

18 (a) Funeral director A. Bozard Evans

(b) Address 1402 Eutaw St Baltimore, Md

APR 5 1945 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 2 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to Jan 6 1945 and that I last saw him alive on March 31 1945.

Immediate cause of death	Duration
Acute myocardial infarction	
Due to Coronary thrombosis	
Due to Coronary arteriosclerosis	
Other Conditions Hypertr. arthritis arteriosclerosis, Sen'l (Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry T. Tubbs MD M. D.

Address Ridge Rd, Raytown Mo Date signed 4/3/45

VS 3

G27578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

Registered No. G27578

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jas & Lombard sts
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyde Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Flossie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-23-1907

8. AGE: Years 37 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Lancaster Va (Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business

FATHER 12. Name Allen Henry Coleman

13. Birthplace Va

MOTHER 14. Maiden Name Bessie Hill

15. Birthplace Va

16 (a) Informant Flossie Coleman

(b) Address 1618 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 7 45 (month) (day) (year)

(c) Cemetery or crematory Lafayette Mem Park

Location Lafayette Md

18 (a) Funeral director Billings & Jackson

(b) Address 916 Penna ave

19 (a) APR 5 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945, to 4/4 1945, and that I last saw h[illegible] alive on 4/4 1945.

Immediate cause of death Respiratory collapse — Duration

Due to Pulmonary TBc

Due to Generalized TBc

Other Conditions C.N.S. syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles D. Shepard M.D.

Address University Hospital Date signed 4/7/45

VS-180

13B

6-27579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 6-27579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert Sts
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) (Life-?)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Towson Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 552 Allegheny ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Thompson Mitchell Horner (THOMPSON MITCHELL HORNER)
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-03-2742

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs Marie L. Horner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1873

8. AGE: Years 71 | Months 7 | Days 7 | If less than one day 0 hr. 25 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Mr Joshua Horner
13. Birthplace Md

MOTHER 14. Maiden Name Jennie Mitchell
15. Birthplace Md

16 (a) Informant Mrs Marie L. Horner-(wife)
(b) Address Towson-Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-6-45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W Monument ave.

19 (a) APR 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/45 19..., at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29/1945, to 4/4/1945, and that I last saw him alive on 4/3/1945.

	Duration
Immediate cause of death Cardiorespiratory failure	
Due to Uremia	6 days
Due to Arteriosclerotic heart disease	
Other Conditions Cerebrovascular accident?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jr Fred Hawkins, Jr M. D.
Address Union Memorial Hosp Date signed 4/4/45

VS 150

G27580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27580

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1748 N. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1748 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha A. Wirth

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wm. Wirth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23rd 1866

8. AGE: Years 78 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Robt. Williams
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mr. John Wirth
(b) Address 4028 Erdman Ave. - Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director C. J. Tammony & Son
(b) Address 1938 E. Lafayette Ave.

APR 5 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 2nd 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1945 to Apr 2 1945, and that I last saw h[illegible] alive on Apr 2 1945

	Duration
Immediate cause of death Arteriosclerotic	
C-V. Disease.	
Contributory Hemorrhage	1939
Due to Unexamined Failure.	3-31-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ea Schemmuck M. D.
Address 842 S Ext Ave Date signed 4-4-45

G27581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G27581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6209 Baltimore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Herbert Lee Silberman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 3, 1933

8. AGE: Years	Months	Days	If less than one day
11	11	1	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Joseph Silberman
13. Birthplace Balto Md

MOTHER
14. Maiden Name Alus
15. Birthplace New York

16 (a) Informant Father
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-45 (month) (day) (year)
(c) Cemetery or crematory Southern Ave
Location Walther Blvd.

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E Baltimore St

19 (a) APR 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 7:00 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 1, at 1945 5:30 P. M. Balto Co.
(b) Where did injury occur Pleasure Hour Riding Academy Pikesville, Md
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fell from horse

23. Signature Howard J. Shulden M.D.
Medical Examiner.
Date signed 4-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G27582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27582

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2135 E. Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Arhew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Aaron Arhew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph -
13. Birthplace Russia

MOTHER
14. Maiden Name Millie -
15. Birthplace Russia

16 (a) Informant Mrs. Sarah Levin
(b) Address 2135 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-45 (month) (day) (year)
(c) Cemetery or crematory Shelwood Gardens
Location Perring Park Rd.

18 (a) Funeral director Jack Levin Inc.
(b) Address 1434 E Baltimore St.

19 (a) APR 5 1945 Interment for Williamsport Md.
(Date rec'd by registrar) (Place)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-45 19 , at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 4/3 1945; and that I last saw her alive on 4/3 1945

	Duration
Immediate cause of death: Coronary Occlusion	9 hrs.
Due to: Arterio sclerosis	9
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Parker M. D.
Address 100 N. Mullen Date signed 4/5/45

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G29583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 622 a

Registered No. G29583

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1147 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE H. WILBOURN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Inez D. Wilbourn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1865

8. AGE: Years 80 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Telegraph Operator

11. Industry or business Retired 15 yrs.

FATHER
12. Name Lewis Wilbourn
13. Birthplace Va.

MOTHER
14. Maiden Name ? Wall
15. Birthplace ?

16 (a) Informant Mr. John L. Wilbourn
(b) Address 3706 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 5 1945 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 4, 1945, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to April 1945 and that I last saw him alive on 4/3 1945

Immediate cause of death: Intestinal Obstruction — Duration: 4 days

Due to: Strangulated Left Inguinal Hernia — 4 days

Due to:

Other Conditions: Generalized Arteriosclerosis — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hope E Roach

Address 3629 E Monument Date signed 4/5/45

X Roach.

G27584 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G27584 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 HUDSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(b) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 HUDSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. BAUERNSCHUB

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARTIN G. BAUERNSCHUB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 17 1878

8. AGE: Years 66 | Months 8 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name THOMAS MILLANY
13. Birthplace IRELAND

MOTHER
14. Maiden Name ELIZABETH BOCH
15. Birthplace MD.

16 (a) Informant MARTIN G. BAUERNSCHUB (HUS)
(b) Address 2930 HUDSON ST.

17 (a) BURIAL (b) Date thereof APR. 6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRA L
Location FREDERICK ROAD.

18 (a) Funeral director Lilly & Zeiler-Sm
(b) Address 403 S. WOLFE ST.

(Date) APR 5 1945 (Registrar) Huntington Wolfe Registrar

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH APR. 2 1945, at 9/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1945 to 4/2 1945 and that I last saw h.r alive on 4/2 1945.

Immediate cause of death: Acute Myocarditis (acute cardiac Dilitation)
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lashley M.D.
Address 441 S. Ellwood Ave. Date signed 4/4/45

VS 150

627583 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

627583 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501½ EASTERN AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501½ EASTERN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. KIRKHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOHN A. KIRKHAM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 16 1857

8. AGE: Years	Months	Days	If less than one day
87	3	17	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name PHILLIP BLETZER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA M. KOPPEL
15. Birthplace GERMANY

16 (a) Informant GEORGE KIRKHAM (SON)
(b) Address 2501½ EASTERN AVE.

17 (a) BURIAL (b) Date thereof APR. 5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Selby Bates & Son
(b) Address 403 S. WOLFE ST.

19 (a) APR 5 (b) 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 2 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 26 1945, to April 2 1945, and that I last saw h[illegible] alive on April 2 1945.

Cause of death	Duration
Myocardial Insufficiency	1 Mo.
Pulmonary Edema	
Due to Cholangiitis (Catarrhal)	10 Days
Due to Septic Deplastes	
Other Conditions Acute Cystitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. G. Bryan M.D.
Address 56 N. Mellen St. Date signed 4/4/45

VS 150

G27586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93B

G27586 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Pine St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write Rural, and give town)
(d) Street No. 305 Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no.

3 (a) FULL NAME Vinton Columbus Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1901

8. AGE: Years 43 | Months 5 | Days 24/25 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Jobbing Work

11. Industry or business

FATHER
12. Name Vinton Hardy (Sr.)
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Maria J. Hinder
15. Birthplace Princess Anne Md.

16 (a) Informant Hester Hocutt.
(b) Address 305 Pine Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) APR 5 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1945 at 1. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1945 to April 2 1945.
and that I last saw him alive on April 2 1945.

Immediate cause of death Myocarditis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 4/5/45

VS 150

G27587 G27587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Nolan Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leslie Patricia McBride

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leslie McBride
13. Birthplace Scranton, Md

MOTHER
14. Maiden Name Dorothy Amos
15. Birthplace Baltimore, Md

16 (a) Informant Dorothy McBride
(b) Address 1206 Nolan Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 3 1945 and that I last saw him alive on April 3 1945

Immediate cause of death: Congenital Syphilis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 2829 Pennsylvania Ave Date signed April 3 1945 M.D.

G27588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 F

G27588 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct... is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 63
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1177 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman C. Mayers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anna Mayers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22-1859

8. AGE: Years 85 | Months 6 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Madalene Neaf
(b) Address 1177 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 6-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Tyson & Flanigan
(b) Address 1426 Light St

19 (a) 4-5-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 4 1945, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 44 to April 4 19 45
and that I last saw h... alive on ... 19...

	Duration
Immediate cause of death Carcinoma of Right Tonsil	5 mos
Due to	
Due to	
Other Conditions Generalized multiple Cancer (Include pregnancy within 3 months of death)	6 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1223 N. Charles St. Date signed 4/4/45

VS 150

X

G27589 2

JO #92331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G27589

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1622 E. Chase St.
(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

8-7

3 (a) FULL NAME Jessie Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Scott

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1918

8. AGE: Years 26 | Months -7- | Days -5- | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Carpenter's Helper

11. Industry or business Fairfield Shipyard

FATHER

12. Name Willie (d)

13. Birthplace Virginia

MOTHER

14. Maiden Name ? ? (d)

15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location a a County Md

18 (a) Funeral director Mrs. Robert J. Elliott, Dft

(b) Address 1129 N. Caroline St.

19 (a) ..... (b) Huntington Williams, M.D.
(Date received by registrar) APR 5 1945 VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945, at 5:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27, 1945, to Apr. 4, 1945, and that I last saw him alive on April 3, 1945.

Immediate cause of death: Pulmonary Tuberculosis bilateral — Duration: 4 mo

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)

(e) Means of injury.....

23. Signature Harold Dillon M. D.

Address Balto City Hosp. Date signed 4/4/45

X

G27590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G27590 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 N. Carolina St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6907 Dunmanway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Joseph T.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1895

8. AGE: Years 49 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Frederick Ludwing
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Katherine Ewig
15. Birthplace Baltimore Md

16 (a) Informant Joseph T. Johnson
(b) Address 6907 Dunmanway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Elm
Location Loch Raven Blvd

18 (a) Funeral director John C Mohan
(b) Address 3000 E Baltimore St

APR 5 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1945, to 4-4 1945, and that I last saw her alive on 4-4 1945.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Cerebral hemorrhage	
Due to hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.
Address St. Joseph's Hospital Date signed 4-4-45

VS 130

G27591 G27591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Petuskis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1910

8. AGE: Years 34 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Connecticut (Town, county, and state)

10. Usual Occupation Steel Heat Treater

11. Industry or business Westinghouse

FATHER 12. Name Andrew A. Petuskis

13. Birthplace Lithuania

MOTHER 14. Maiden Name Anna Krivasa

15. Birthplace Lithuania

16 (a) Informant Francis Petuskis

(b) Address 1206 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Near Britain, Connecticut

18 (a) Funeral director Joseph Kaminskas

(b) Address 682 Washington Blvd

19 (a) APR 5 1945 (Date filed by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epidural Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mueseler M.D. Medical Examiner.

Date signed April 5, 1945.

VS 151

G27592 BALTIMORE CITY HEALTH DEPARTMENT 1937 G27592
Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Compass Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Waldon Sturgill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Pearl
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) 3-2-97

8. AGE: Years	Months	Days	If less than one day
48	1		hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation fireman
11. Industry or business

FATHER 12. Name Melvin Sturgill
13. Birthplace Virginia

MOTHER 14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Pearl Sturgill
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Trans. (burial, cremation, or removal) (b) Date thereof 4-5-45 (month) (day) (year)
(c) Cemetery or crematory
Location Marion Va.

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave. Essex

19 Apr 5 1945 Huntington Williamsport
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at 11:17 AM

21. I certify that death occurred on the date above stated, that I attended deceased from April 3 1945 to April 4 1945 and that I last saw him alive on April 4 1945.

Immediate cause of death	Duration
Cardiac arrest	
Due to Coronary thrombosis	
Due to Hypertensive cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William T. Dietz
Address Johns Hopkins Hospital 4/4/45

G27593 G27593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Highland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Henry J. Davies

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Davies

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 7/30/1872

8. AGE: Years 72 | Months 8 | Days 3 E.R. | If less than one day ____ hr. ____ min.

9. Birthplace Wales, England
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name
13. Birthplace Wales, England

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Davies
(b) Address 612 N. Highland avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 6 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Avenue

18 (a) Funeral director Frederick D. Miller Inc
(b) Address 3019 E. Monument Street

19 (a) 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

5

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 3 1945

VS 151

X

627594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

627594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4011 Walbrad Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Walbrad Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary M. Lind

3 (b) If veteran, name war C | 3 (c) Social Security Account No. ns

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Sebastian Lind
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1856

8. AGE: Years	Months	Days	If less than one day
89	2	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Michael Dampsman
13. Birthplace Germany

MOTHER
14. Maiden Name Sabina Luntz
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Fuegel
(b) Address 4011 Walbrad Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6th 1945 (month) (day) (year)
(c) Cemetery or crematory London Park Cem. Location Baltimore

18 (a) Funeral director Gill Bros.
(b) Address 3109 Frederick Ave

19 (a) Clayton Williams, M.D. (Date received by registrar) Registrar

APR 6 1945

Approved

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1940 to 4/4 1945 and that I last saw h[illegible] alive on 4/3 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hrs 45 min

Due to General Arterio-Sclerosis & Hypertension — Duration 5 yrs

Due to — Duration

Other Conditions Paralysis left side — Duration 2 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence 9-16-44
(c) Where did injury occur? 4011 Walbrad Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no (Specify type of place)
(e) Means of injury Fell down stairs.

23. Signature Elliot W. Johnson M.D.
Address 3432 Frederick Ave Date signed 4-5-45 M. D.

G27595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

84a

Registered No. G27595

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~519 Oakland Ave~~ Baltimore-12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Oakland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Judith Inez Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or ~~divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apl 5-1945

8. AGE: Years | Months | Days | If less than one day 1 hr. 16 min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Edward Thomas Myers

13. Birthplace Baltimore - Md

MOTHER 14. Maiden Name Marion Inez Geiger

15. Birthplace Baltimore Md.

16 (a) Informant Edward T. Myers

(b) Address 519 Oakland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 6-1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Bertram Rose

(b) Address 2324 N. Charles St.

19 APR 5 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-1945, to 4-5-1945, and that I last saw he/she alive on 4-5-1945.

Immediate cause of death	Duration
Congenital atelectasis	16 hrs
Due to Incomplete development of lung structures	
Due to	
Other Conditions Meningocele ? diag (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Stichel M. D.

Address Bon Secours Hosp. Date signed 4/5/45

161a

G27596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27596

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1222 Riverside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Riverside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Serra

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Oreste Serra
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Nov. ?, 1869

8. AGE: Years	Months	Days	If less than one day
75	4		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Alice Beal
(b) Address 1222 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Wm. J. Kenny Inc; L. S. Lear
(b) Address 715 Light St.

19 APR 5 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1938; to 4-4 1945, and that I last saw her alive on 4-3- 1945.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Cardio Renal disease	7 yrs.
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence M. Lear
Address 11 E. Chase St. Date signed 4/5/45 M. D.

VS 150

G27597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G27597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution:
Mansford General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore # 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry O. Rapold

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of ~~husband~~ or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14th 1883

8. AGE: Years	Months	Days	If less than one day
61	6	21	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Clerk - Foreman
11. Industry or business Consolidated Engineering Co.

FATHER
12. Name Rapfpold
13. Birthplace Unknown

MOTHER
14. Maiden Name Cassandra Hayward
15. Birthplace Unknown

16 (a) Informant Ruth Stewart
(b) Address 12 Oakdale Ave Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery or crematory Orem
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

APR 6 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1945, at 4:30 AM.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1945 to 4/5 1945; and that I last saw h~~im~~ alive on 4/4 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 days
Due to Arteriosclerotic C.V. Disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl Hospital Date signed 4/5/45

X

G-27598 X ✓ G-27598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 86 - Dundalk ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil Clout - Sr. (Cecil K Crow, Sr)

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pauline Crow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-02

8. AGE: Years	Months	Days	If less than one day
42	5	2	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Md Dry Dock

FATHER 12. Name William Crow
13. Birthplace ?

MOTHER 14. Maiden Name Madeline Story
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremated (b) Date thereof 4/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lindens
Location Lindens Texas

18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 St Paul St

19 (a) APR 6 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3 1945, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1945 to 4-3 1945 and that I last saw h[illegible] alive on 4-3 1945.

Immediate cause of death: Intestinal Obstructions & Peritonitis — Duration: 8 da
Due to: Adhesions
Due to: Old ruptured appendix — 5 yrs
Other Conditions? Pulm. edema or embolism - Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Adhesions
of autopsy: Peritonitis & Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allan C. Woods Jr.
Address Johns Hopkins Hospital Date signed 4/7/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G27599 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 E 27th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 E 27th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ann Curtis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	0	hr. min.

9. Birthplace Co Wexford, Ireland (Town, county, and state)
10. Usual Occupation Retired,
11. Industry or business Sta. Fireman

FATHER
12. Name John Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Anastasia Redmond
15. Birthplace Ireland

16 (a) Informant Miss Ann Doyle
(b) Address 339 E 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945, at 11.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19, 1945 to April 4, 1945 and that I last saw h[illegible] alive on Apr. 4, 1945.

Immediate cause of death Diabetic Gangrene of right Foot. — Duration 4 months

Due to Diabetes

Due to ✓

Other Conditions Chronic Myocarditis — Duration 1 year.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature Francis M. Ogden M. D.
Address 2701 N. Calvert St Date signed 5/1/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627600 TN. 80084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

627600 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 2- I- 5 -days 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 748 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Alexander Royster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife Anna.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1900

8. AGE: Years 45 | Months 0 | Days 17 | If less than one day hr. min.

9. Birthplace N. C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Royster
13. Birthplace N. C

MOTHER
14. Maiden Name Betty ?
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Leonard L. Burns & Son
(b) Address 104 W Montgomery St

19 (a) APR 6 1945 (Date rec'd by Registrar) (b) Signature of Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1945 19 5.15 P.M at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27-43 19 to 4-2-45 19, and that I last saw h im alive on Apr. 2 19 45

Immediate cause of death Tuberculous empyema — Duration 2 mo.

Due to Pulmonary tuberculosis — Duration 2 yrs

Due to

Other Conditions T.b. epididimitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Fallon M.D.
Address Balto City Hosp Date signed 4/4/45

G27601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

G27601 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4814 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4814 Keswick Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) **FULL NAME** Margaret Lindsay Blanchard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Peter P. Blanchard

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26 1878

8. AGE: Years 66 Months 10 Days 10 If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Early Lindsay

13. Birthplace Queens Co N.C.

MOTHER 14. Maiden Name Charlotte Gittings

15. Birthplace Md

16 (a) Informant Peter P. Blanchard

(b) Address 4814 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 7 1945 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto. Md.

18 (a) Funeral director Henry H. Jenkins & Son Co

(b) Address McCulloh & Richard Sts

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1945; at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1945 to April 5th 1945, and that I last saw h.. alive on April 4th 1945.

Immediate cause of death	Duration
Exclusion of uterus and appendages	
Due to Cancer	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operation Carcinoma (suspected) in pelvic organs
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature J. A. Blackard M. D.

Address 130 W. Saratoga St Date signed April 5 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27602 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3054 BRIGHTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3054 BRIGHTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA. H. SOMMER.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB-26-1866

8. AGE: Years	Months	Days	If less than one day
79	1	10	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WORK.

11. Industry or business AT HOME

FATHER
12. Name REV M. C. SOMMER
13. Birthplace GERMANY.

MOTHER
14. Maiden Name EMILIE · H. FRITZSCHE
15. Birthplace GERMANY

16 (a) Informant MRS G.F. RUECKERT
(b) Address 3054 BRIGHTON. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-7-45 (month) (day) (year)
(c) Cemetery or crematory ST PAULS CEMETERY
Location DRUID HILL PARK.

18 (a) Funeral director Mrs Chas G B Rohde
(b) Address 2327 Edmondson Ave

19 (a) 4/6/45 (Date of daily registration) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 5 1945, at 5.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1945, to April 5 1945, and that I last saw h.e alive on March 4 1945.

Immediate cause of death	Duration
Hardening Renal Condition	1
Due to Preceding Pneumonia	
Due to Bronchial type	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation? No

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? No (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M Ericson M. D.

Address 612 W 40 Date signed

627603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627603 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto L
(c) City or town Raspeburg Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Skandara

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-5834

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nellie G.
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Aug 3-1905

8. AGE: Years	Months	Days	If less than one day
39	8	2	hr. min.

9. Birthplace Md - Balto County
(Town, county, and state)
10. Usual Occupation Welder
11. Industry or business

FATHER
12. Name Frank Skandara
13. Birthplace Czekoslavia

MOTHER
14. Maiden Name Mary Bursick
15. Birthplace Czekoslovakia

16 (a) Informant Nellie G. Skandara
(b) Address Ridge Road - Raspburg

17 (a) Burial (b) Date thereof April 9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director John C. Tilley Inc.
(b) Address 2435 E. Oliver St.

19 APR 6 1945 Huntington Williams M.D.
(Date rec'd by reg'r) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1945 to 4-5 1945 and that I last saw him alive on 4-5 1945

Immediate cause of death Hypertension

	Duration
Due to Malaria (Treatment for General Paresis)	
Due to	
Other Conditions C.N.S. Syphilis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature F. M. Shipley M. D.
Address University Hosp. Date signed 4-5-45

X

G27604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27604

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 Wilkens Ave
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rubin Rueppew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rachel Rueppew

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name David -
13. Birthplace Russia

MOTHER
14. Maiden Name Sofrs
15. Birthplace Russia

16 (a) Informant Family
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-45 (month) (day) (year)
(c) Cemetery or crematory Sinai Hebrew Cem
Location Wash. Blvd

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St

19 (a) APR 6 1945 (Date rec'd by registrar) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-45 19 at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2/ 1945, to 4-5- 1945, and that I last saw him alive on 4/4/ 1945

Immediate cause of death Degeneration Cardio Vascular Renal.
Arterio Sclerosis.

	Duration
Due to	
Due to	
Other Conditions Prelonged Bedding	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norfolk Mitchell M. D.
Address 215 W Wilkens Ave Date signed 4/5/45

VS 150

X

627605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

627605
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 W. West st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 W. West St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hattie Summerfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1882

8. AGE: Years 62 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace A. A. Co. Md (Town, county, and state)

10. Usual Occupation Factory

11. Industry or business Rag Factory

FATHER
12. Name James Pinder
13. Birthplace Md

MOTHER
14. Maiden Name Hattie
15. Birthplace Md

16 (a) Informant Sarah Berger
(b) Address 506 W. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Daniel L. Burns
(b) Address 108 W Montgomery St Huntingtown Williams

19 (a) 1945 (Date rec'd by Registrar) (b) Registrar

APR 6

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 2 1945 at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23 1945 to Apr. 2 1945 and that I last saw h[illegible] alive on Apr. 1 1945.

Immediate cause of death a. Chronic Myocarditis — Duration about 6 mos
Due to b. Unknown
Due to c.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Gaines M.D.
Address 665 W. Baltimore Date signed 4/6/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

627606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 W. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 W. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Onancock Va.
(Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name Bethe Parks
15. Birthplace Va.

16 (a) Informant Charles Henson
(b) Address 1620 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)

(c) Cemetery or crematory
Location Onancock Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave.

19 (a) Date rec'd by registrar PR 6 1945 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed April 5 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FO... DING

G27607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G27607

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Plus correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 N. Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 Jean

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Patek

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary Patek
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Dec 25 1877

8. AGE: Years	Months	Days	If less than one day
67 68	3	10	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Waclaw Patek
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs Mary Patek
(b) Address 1805 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County

18 (a) Funeral director Mrs Mary Weber
(b) Address 401 S. Chester Street

19 APR 6 1945 (Date rec'd by registrar) (b) Huntingdon Pennsylvania Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1945 to April 5 1945 and that I last saw him alive on April 5 1945

Immediate cause of death	Duration
Coronary Thrombosis	4/5/45
Due to Chronic Endocarditis	1/1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J Roamer

Address 801 N Kenwood Ave Date signed April 6/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94Q

Registered No. G27608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate Lane
(c) Hospital or institution:
Pinecrest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1956 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: FREDERICK PAUL

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1872

8. AGE: Years 73 | Months 1 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John F. Paul
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Imhoff
15. Birthplace Germany

16 (a) Informant Mrs. Caroline Hallman
(b) Address 1956 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 6 1945 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945 at 8:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to April 4 1945
and that I last saw h. alive on 4/4/45 19

Immediate cause of death: Repeated coronary thromboses — Duration: 2 Months

Due to:

Due to: (a)

Other Conditions: General Arterio sclerosis — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. P. Calyer M. D.
Address 336 Park Ave. Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D (627609)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 S. STREEPER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. STREEPER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARY SOBUS

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife JOHN SOBUS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name JOSEPH RUSIN

13. Birthplace POLAND

MOTHER 14. Maiden Name UNK.

15. Birthplace POLAND

16 (a) Informant JOSEPH SOBUS

(b) Address 615 S. STREEPER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 9 45 (month) (day) (year)

(c) Cemetery or crematory HOLY ROSARY

Location BALTIMORE

18 (a) Funeral director Fred W. Ozarowski

(b) Address 1930 Eastern Ave, Balto, Md.

19 (a) Date rec'd by Registrar APR 6 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 4 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 2 1945 to APRIL 4 1945, and that I last saw h E alive on APRIL 4 1945

Immediate cause of death PULMONARY EDEMA — Duration 4/4/45

Due to ARTERIO SCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE — 9 MONTHS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph F. Drenga M.D.

Address 207 N. Chester St Date signed 4/6/45

627610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

627610 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E Baldeston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorenzo Miles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Crawfordville Ga. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wills Miles
13. Birthplace Crawfordville Ga.

MOTHER
14. Maiden Name Annie Evans
15. Birthplace Crawfordville Ga.

16 (a) Informant Mary E. Meadows
(b) Address 334 Hudson St Detroit Mich.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-1945 (month) (day) (year)
(c) Cemetery or crematory New Salem
Location Washington Ga.

18 (a) Funeral director Byron & Jamie H. Wright
(b) Address 721 Aisquith St. Balto, Md.

19 (a) APR 6 1945 (Date rec'd by Registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945, at 9 05 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of brain; ~~Edema~~ Edema of lungs, traumatic
Due to (over)
Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April at 1 1945 - 4/1 8 P M.
(b) Where did injury occur Baldeston St Mrs Charles
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? yes
(d) Means of injury Car fell down elevator shaft

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 2 1945

VS 151

G27611

BALTIMORE CITY HEALTH DEPARTMENT ✓ G27611

CERTIFICATE OF DEATH 1370

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Wyman Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Julia Trueheart Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1873

8. AGE: Years	Months	Days	If less than one day
71	9	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Grocery

11. Industry or business

FATHER
12. Name Edward L. Green
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sophia A Pedicord
15. Birthplace Howard Co. Maryland

16 (a) Informant Mrs. Julia Green
(b) Address 2922 Wyman Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Maryland

18 (a) Funeral director Young Byers
(b) Address 5005 Park Heights Ave.

19 (a) APR 6 1945 Thurlington Williams Md. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1945 to 4-4 1945 and that I last saw him alive on 4-4 1945.

Immediate cause of death Cardiac failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-3-45

Major findings of operation: Hypertrophied prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Thomson M. D.

Address Date signed

VS 150

627612 BALTIMORE CITY HEALTH DEPARTMENT ✓ 627612
CERTIFICATE OF DEATH 1170 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1911

8. AGE: Years 33 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Western Electric

FATHER 12. Name George Scott
13. Birthplace N.C.

MOTHER 14. Maiden Name Henrietta Lane
15. Birthplace N.C.

16 (a) Informant Mrs. Henrietta Scott
(b) Address 2314 Bolton St Philadelphia

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof April 9, '45 (month) (day) (year)

(c) Cemetery or crematory
Location Philadelphia, Penn.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b)
(To be rec'd by registrar) Registrar

194[illegible]
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1945 at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 4/5 1945 and that I last saw h/m alive on 4/5 1945

	Duration
Immediate cause of death Respiratory failure	11 days
Due to Uremia	
Due to Diffuse peritonitis	
Other Conditions Perforated gastric ulcer	

(Include pregnancy within 3 months of death)

Date of operation 3/29/45
Major findings of operation perforated ulcer
of autopsy: same + peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard J. Tealord Jr. M.D.
Address University Hospital Date signed 4/6/45

G27613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27613 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Leo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Wagners Pt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Leo St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katarzyna Zebron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 Months Days If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Box Maker

11. Industry or business Eastern Box Co.

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant John Zebron
(b) Address 3837 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. L. Fialkowske
(b) Address 2007 Eastern Ave

19 (a) 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1945 to 4/4 1945 and that I last saw her alive on 4/3 1945.

Immediate cause of death	Duration
Chronic myocarditis	
Due to Influenza	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Cohen M. D.
Address 203 Dolphin Date signed

VS 190

G27614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27614 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 841 E. Chase St.
(c) Hospital or institution: at Home 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 841 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Scully

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1861

8. AGE: Years 84 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business House Maid

FATHER
12. Name James Scully
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Mullen
15. Birthplace Ireland

16 (a) Informant Mrs. Isabella Finn
(b) Address 841 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conflenti & Son
Address 924 E. Eager St.

19 (a) APR 194[illegible] Washington Williams, M.R. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 28 19 to Feby 28 19 45 and that I last saw h[illegible] alive on Feby 28 | 45

Immediate cause of death: Coronary infaction — Duration

Due to: Cerebral arteriosclerosis

Due to:

Other Conditions: & Hypertentions

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Homsten, M.D.
Address 733 Ashburton St. Date signed 4/5/45

For Dr. John R. Davis, by Howard J. Mercein, M.D.

627615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

627615

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Gough Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Gough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JANE REESE

3 (b) If veteran, name war ---

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Martin Reese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John T. Slocum
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Shnawolf
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Bauernfeind
(b) Address 3406 Gough St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

PR 6 1945 (c) Date received (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3-45 19__ to 4-5-45 19__, and that I last saw h[illegible] alive on 4-4-45 19__.

Immediate cause of death Coronary thrombosis — Duration 2 days
Due to Hypertensive cardiovascular disease
Due to Diabetes
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Costantino M.D.
Address 234 S. Chapel St. Date signed 4-5-45

VS 190

X

G27616

CWK- 88048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G27616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10- 17
(e) Length of stay in Baltimore (yrs., mos., or days) 65- 2 - 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Dickerson,

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29-1880

8. AGE: Years	Months	Days	If less than one day
65	2	5	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Gibbs Packing Co.

FATHER
12. Name Frank Dickerson
13. Birthplace Meryland

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ?

16 (a) Informant Records, Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof April 7-45
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Milton Schilling (25)
(b) Address 3914 S Hanover St

19 (a) (Date rec'd) APR 9 1945 (b) Washington Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 3- 1945, to Apr. 4 1945, and that I last saw him alive on Apr. 4 1945

Immediate cause of death	Duration
Pulmonary Hemorrhage	4 min.
Due to Pulmonary tuberculosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lisa Lalumia M.D.
Address Balto. City Hosp. Date signed 4/4/45
Balto - Md.

WB-134

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Glenmore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 71 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Glenmore Avere
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Louis Felber

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma May Spicer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1873

8. AGE: Years	Months	Days	If less than one day
71	10	29	hr. min.

9. Birthplace Phila. Pa
(Town, county, and state)
10. Usual Occupation Veterinarian
11. Industry or business

FATHER
12. Name Simon Louis Felber
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Louise Schmidt
15. Birthplace Phila. Pa

16 (a) Informant Mrs. Emma May Felber
(b) Address 3008 Glenmore Avenue

17 (a) Burial (b) Date thereof 4-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 5/15 A.M. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 15 1944 to April 4 1945 and that I last saw him alive on April 2 1945

Immediate cause of death	Duration
Coronary Occlusion	1 Year
Due to	
Due to	
Other Conditions Angina Pectoris Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

R. Eyler PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury None
23. Signature R. Eyler Coady M.D.
Address 5106 Harford Rd Date signed 4/5/45 M. D.

VS 150

Huntington Williams

G27618 BALTIMORE CITY HEALTH DEPARTMENT G27618
Registered No.

CERTIFICATE OF DEATH 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 779 W Lexington St.
(If rural give location)
(e) Citizen of foreign country? Italy (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Troggi TR 221

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Josephine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1888

8. AGE: Years	Months	Days	If less than one day
56	11	13	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shipyard worker
11. Industry or business

FATHER
12. Name Louis Troggia
13. Birthplace Italy

MOTHER
14. Maiden Name Celestine Columbia
15. Birthplace Italy

16 (a) Informant Josephine Troggi
(b) Address 779 W. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Eutaw Place

19 (a) 6 1945 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1945; at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945 to 4/5 1945 and that I last saw h.. alive on 4/5 1945

Immediate cause of death Cardiac failure.
Duration

Due to an whelming Uremia

Due to Diabetes Mellitus

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Stanley Mc M.D.
Address [illegible] Date signed 4/6 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

172

G27619

Registered No. 2078

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st. St.

(c) Hospital or institution:

US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2862 Harford Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Wheeler, John Madison

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1873

8. AGE: Years	Months	Days	If less than one day
71	7	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Marine Inspector

11. Industry or business Maritime Service

FATHER

12. Name John Wheeler

13. Birthplace St. Mary's Co., Md.

MOTHER

14. Maiden Name Booze Columbia

15. Birthplace Baltimore, Md.

16 (a) Informant Records, US Marine Hospital

(b) Address , Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Co. Location North ave & Gay St.

18 (a) Funeral director John Ouellet Sons

(b) Address 1900 Eutaw Place

(c) Date received APR 6 1945 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 19 45 to April 4 19 45, and that I last saw him alive on April 4 19 45.

Immediate cause of death	Duration
Massive bilateral pulmonary edema and congestion with bilateral pulmonary effusions.	2 days
Due to Comminuted fracture, upper third left femur.	12 days
Due to	
Other Conditions Catarrhal jaundice, syphilis of undiagnosed site (Include pregnancy within 3 months of death)	

Date of operation 3/29/45

Major findings of operation: Open reduction of left femur

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident 25/6

(b) Date of occurrence March 23 1945 M

(c) Where did injury occur? US Mission Salvador Nr. Fairfield (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ship (volunteer work) While at work? yes (Specify type of place)

(e) Means of injury Fell through deck

23. Signature Benjamin J. Jones M. D.

Address US Marine Hospital Baltimore, Md. Date signed 4/5/45

Approved by Howard J. Whitacre, M.D.

627620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

627620 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Homewood Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie H. Baylies

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1869

8. AGE: Years 75 | Months 4 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John H. Baylies
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia Ann Roche
15. Birthplace Cambridge, Md.

16 (a) Informant John H. Baylies
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1928 to April 4 1945, and that I last saw her alive on April 3 1945.

Immediate cause of death	Duration
Hypertension arterio-sclerotic cardio vascular disease	Prior to 10/17/40
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas C. Judd M. D.
Address 222 Wendover Road Date signed 4/6/45

G27621 ✓ X G27621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County.....
(c) City or town Berwick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 Summerhill Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William H. Kline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1898

8. AGE: Years 46 | Months 5 | Days 10 | If less than one day .....hr. .....min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Sutter Lumber Co.

FATHER
12. Name Peter Kline
13. Birthplace Pa.

MOTHER
14. Maiden Name Maud Bower
15. Birthplace Pa.

16 (a) Informant William Kelcher
(b) Address 1195 E. 3rd St., Berwick, Pa.

17 (a) Burial-Removal (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)

(c) Cemetery or crematory Pine Grove Annex
Location Berwick, Pa.

18 (a) Funeral director W. J. Tidsman & Sons
(b) Address North & Penn Ave.

19 (a) 1945 4-6-45 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Pa.
Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-6-45 12/6 20 10 A.M.

(b) Where did injury occur? Marine Hosp. Grounds Wyman Park Annex

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes

(d) Means of injury Crushed in cave in.

23. Signature Robert Lee Gutshall M.D.
Medical Examiner.

Date signed April 6 1945

X

627622 BALTIMORE CITY HEALTH DEPARTMENT 627622

CERTIFICATE OF DEATH 95c

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N. Bethel St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Amos D. Crumpler

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 219-01-2813

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: ARTHalia Crumpler

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-17-1893

8. AGE: Years 51 | Months 3 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Fayetteville N.C.
(Town, county, and state)

10. Usual Occupation Ministers

11. Industry or business .....

FATHER
12. Name Thomas Crumpler
13. Birthplace N.C.

MOTHER
14. Maiden Name Henrietta -
15. Birthplace N.C.

16 (a) Informant Arthalia Crumpler
(b) Address 413 N. Bethel St

17 (a) Burial (b) Date thereof 4-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location .....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantleyan

19 (a) ..... (b) .....
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation
Pulmonary Emphysema

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 6 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 6 1945

627623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

627623
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W. Lexington St.
(b) Street address 1312 [redacted]
(c) Hospital or institution:

19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 [redacted] Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Kothe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lillian Manns Kothe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 2, 1878

8. AGE: Years 66 | Months 7 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Insurance Agent--Retired

11. Industry or business

FATHER
12. Name Charles F. Kothe
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hahn
15. Birthplace Germany

16 (a) Informant Miss Isabelle Manns
(b) Address 1312 W. Lexington St.

17 (a) Burial (b) Date thereof April 9, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director [redacted]
(b) Address 1005 W. Baltimore St.

APR 6 1945
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1945, at 1.35 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh H. McNally M.D.
Medical Examiner.
Date signed 4/6/45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. 6-27624

27624

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard Sts
(c) Hospital or institution:
Univ Hosp. University 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-yr
(e) Length of stay in Baltimore (yrs., mos., or day 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Holmes Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ware. Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-20-1882

8. AGE: Years 62 | Months 9 | Days 16 | If less than one day ____ hr. — min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Henry Ware
13. Birthplace ?

MOTHER 14. Maiden Name Isabella ?
15. Birthplace ?

16 (a) Informant John Ware Jr.
(b) Address 1610 Waldo st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wellings & Jackson
(b) Address 916 Penna ave

19 (a) APR 7 - 1945 (Date rec'd by local registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945 at 6.55 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1945 to 4-5 1945 and that I last saw him alive on 4-5 1945

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic cvd —

Due to

Other Conditions Carcinoma of esophagus.
(Include pregnancy within 3 months of death)

Date of operation 6.9.45

Major findings of operation: Ca of esophagus & metastasis

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. B. Marment M.D.
Address Univ Hosp Date signed 4/6/45

G27625

JO #92904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27625 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimire City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 W. Fairmont Ave. 612
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Will McLain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July ? 1867 ?

8. AGE: Years	Months	Days	If less than one day
77 78?	? 9	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business Kramer Co. 16 S. Eutaw

FATHER
12. Name Will (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Zana Sanders (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 578 N. Biddle St.

19 (a) 4-7-45 (Date received by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2, 1945, to April 4, 1945, and that I last saw h im alive on April 4, 1945.

Immediate cause of death: Pulmonary Edema — Duration 4 Hrs

Due to: Acute Cardiac Failure — Duration ?
Anemia — 4

Due to: — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-3-45

Major findings of operation: Edema of Buttocks

of autopsy Cardiac failure + edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Perry M.D. M. D.
Address 16 C 2 Date signed 4-6-45

G27626

BALTIMORE CITY HEALTH DEPARTMENT

TN. 15610

CERTIFICATE OF DEATH 45F

Registered No. G27626

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18- 2- 16-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Edward Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16th, 1872

8. AGE: Years	Months	Days	If less than one day
72 ?	11	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Henry Dange Boone
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Dailey
15. Birthplace D. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 4/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John F. Lahey
(b) Address 3711 Eastern Ave

19 (a) 4/7/45 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

APR 7 1945

VS 150

MEDICAL CERTIFICATION 6.45 P.M

20. DATE OF DEATH April 1st, 1945 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15- 1927 to April 1st 1945
and that I last saw him alive on 4-1-45 19

Immediate cause of death Carcinoma of Nasopharynx
Gen. Arteriosclerosis

Duration 2 yrs ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Perry M.D.
Address BC Hd Date signed 4-3-45 M. D.

X

627627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

627627 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 N. Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Bentalou (If rural give location)
(e) Citizen of foreign country? Yes No (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME William Wynne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1879?

8. AGE: Years	Months	Days	If less than one day
65	8	12	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Head Porter
11. Industry or business Southern Hotel

FATHER
12. Name Peter Wynne
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Clark
15. Birthplace Ireland

16 (a) Informant James Wynne
(b) Address 9 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-45 (month) (day) (year)
(c) Cemetery or crematory Catherdral
Location Baltimore Md

18 (a) Funeral director George A Fahey
(b) Address Fulton Ave & Fayette

19 (a) (Date rec'd by registrar) APR 7 - 1945 (b) Huntington Publishing Co.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Hanging

Due to

Other Conditions Mental Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 6 1945 at 7 A.M.
(b) Where did injury occur? 9 N. Bentalou St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged self

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed April 6 1945

G27628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G27628

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 Enfield Rd
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Enfield Road (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Ashton Thumm

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth E. Thumm
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) March 30 1896

8. AGE: Years 55 | Months 0 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Mfgrs Sales Agt
11. Industry or business Machine Tools

FATHER
12. Name Wm G. Thumm
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Anna D Still
15. Birthplace Phila Pa.

16 (a) Informant Mrs Ruth E. Thumm (wife)
(b) Address 103 Enfield Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Clinard Memorial
(b) Address 108 W Mt Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to April 1 1945, and that I last saw him alive on April 4 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 mos 12 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G W Bellups M. D.
Address 2224 N. North Ave. Date signed 4/5/45

VS 15a APR 7 - 1945

G27629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G27629 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Won (WON-JIM)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Chinese	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1865

8. AGE: Years	Months	Days	If less than one day
Abt 80	—	—	hr. min.

9. Birthplace China
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace China

MOTHER
14. Maiden Name Don't Know
15. Birthplace China

16 (a) Informant Lee Wah (Cousin)
(b) Address 312 Park Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn - Md

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOOSEN SUC.) 105 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

APR 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at 4 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pyelonephritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed April 5 1945

VS 151

X

G27630 G27630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 177

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 W. Henrietta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. Henrietta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Chase

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-09-5837

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ethel J. Chase
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/1883

8. AGE: Years 61 | Months | Days 19 | If less than one day hr. min.

9. Birthplace Washington D.C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Sugar Refinery

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Ethel J. Chase
(b) Address 121 W. Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md.

18 (a) Funeral director Israel L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) APR 7 1945 (Date received by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/ 1945, at 1:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/3/ 1945, to 4/5/ 1945, and that I last saw h[illegible] alive on 4/5/ 1945

Immediate cause of death — Duration

Acute Gastro Enteritis

Due to Stomach poisoning 2 dys.

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter D. Taylor

Address 1522 Harlem Ave Date signed 4/6/45

G27631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G27631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 W. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIE MAE SHEPPARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) march 1, 1920

8. AGE: Years	Months	Days	If less than one day
24 25	11	4	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Mc Kenley Sheppard
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Attianson
15. Birthplace N. C

16 (a) Informant Mary Sheppard
(b) Address 638 W. Mulberry St

17 (a) Burial (b) Date thereof 4-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wilson N. C.
Location Wilson N. C.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

19 (a) APR 7 - 1945
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, 2:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Multiple stab wounds
Internal Hemorrhage
Due to Severed cord

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-5-45 at 11:15 P. M.
(b) Where did injury occur? 638 W. Mulberry Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Stabbed

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 4-6-45

VS 151

G27632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No. G27632

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Sussex Road, Towson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon W. Crowthers

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: nine

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Ethel M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-95

8. AGE: Years 50 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Penna Railroad

FATHER
12. Name Theodore James Crowther
13. Birthplace Unknown

MOTHER
14. Maiden Name Lillian Boyer
15. Birthplace Boyertown, Pa.

16 (a) Informant Ethel Crowthers
(b) Address 509 Sussex Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Woodlawn Md

18 (a) Funeral director Milhorn & Son
(b) Address 1217 E Fayette St

19 APR 7 - 1945 (Date rec'd by Local Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1945, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-45 19..., to 4-6-45 19..., and that I last saw h/im alive on 4-6-45 19...

Immediate cause of death	Duration
Pulmonary embolism	
Due to Ulcerative colitis & thrombosis of mesenteric veins	
Due to	
Other Conditions Calculus in Left kidney pelvis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Human calculus; Ulcerative colitis
of autopsy: Pulmonary Embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Handy M. D.
Address Md. Gen. Hosp. Date signed 4-6-45

120 R

627633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 557

627633 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Lamont Avenue
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Lamont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: GEORGE W. DANIELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	maried

6 (b) Name of husband or wife: Frances May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1880

8. AGE: Years	Months	Days	If less than one day
65	2	15	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Meat Packer

11. Industry or business: Swift & Co.

FATHER
12. Name: George W. Daniels
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Ida Collins
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Frances M. Daniels
(b) Address: 1603 Lamont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

APR 7 - 1945 (Date rec'd by Registrar) (b) Huntington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1945 to April 6 1945, and that I last saw him alive on April 4 1945.

Immediate cause of death	Duration
Squamous cell Carcinoma of rt antrum with	
Due to rapid growth &	14 Month
Due to met to Liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. N. Saumenkemper M.D.
Address 145 E. Cager St Date signed 4/6/45

VS 150

G-7634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G-7634

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green

(c) Hospital or institution: University 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4619 Minnesota Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Herbert Auer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charlotte

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct 14th 1893

8. AGE: Years	Months	Days	If less than one day
51	5	22	hr. min.

9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual Occupation Asst Supt. Mails

11. Industry or business U.S. Govt.

FATHER

12. Name William Auer

13. Birthplace Germany

MOTHER

14. Maiden Name Bernhardina Kuttelmeyer

15. Birthplace Germany

16 (a) Informant Wilhelmina Auer

(b) Address 4619 Minnesota Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/9/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto

Location " Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 APR 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams Undertaker

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/45 19 , at 5.04 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1945 to 4/6 1945 and that I last saw h. alive on 4/6 1945

Immediate cause of death Peritonitis — Duration

Due to Perforated ulcer

Due to C.A. & Pneumonia bronch.

Other Conditions Gen. metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible] MD

Address [illegible] Date signed 4/8/45

VS 150

Cowley X

G27635 4-15

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 63B

Registered No. G27635

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2017 Dukeland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Dukeland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie L. Cochran
3 (b) If veteran, name war —
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 24 1876
8. AGE: Years 68 Months 5 Days 15 If less than one day hr. min.
9. Birthplace Randolph Co N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Rev. Martin J Lock
13. Birthplace NC
MOTHER 14. Maiden Name Nthela Brown
15. Birthplace NC
16 (a) Informant Frank Cochran
(b) Address 2017 Dukeland St
17 (a) Burial (b) Date thereof 4/8/45 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ELEAZER CHURCH
Location ELEAZER N. C.
18 (a) Funeral director Wilhoit Funeral Home Inc
(b) Address 1217 E Pratt St
19 (a) Date rec'd by registrar APR 7 - 1945 (b) Emiting Jon Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945, at 11:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1945, to April 6 1945, and that I last saw h[illegible] alive on April 6 1945.

	Duration
Immediate cause of death Myocardial insufficiency	10 days
Due to Hypostatic pneumonia	7
Due to chronic Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George T Kemp
Address 3232 Edmondson Ave Date signed 4/7/45

VS 150

G27636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G27636 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 Brentwood ave
(c) Hospital or institution: Balto md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County —
(c) City or town Balto city md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Brentwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarido M Beck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F1 | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) may 14 - 1871

8. AGE: Years 74 | Months 10 — | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Peter J
13. Birthplace Md

MOTHER
14. Maiden Name Emma M Rippel
15. Birthplace Maryland

16 (a) Informant Agnes L Foster
(b) Address 2602 Brentwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Foulon
(b) Address 2359 West Blvd

19 (a) (b) Registrar

APR 7 1945 Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at 6:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1939 to Apr. 4 1945 and that I last saw h&r alive on Apr. 4 1945

Immediate cause of death Coronary Occlusion — Duration 4/4/45

Due to Arterio sclerotic cardio vascular disease — Duration ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carey Rosking M. D.

Address 326 W Lombard St Date signed 4/6/45

X

Dr. Gordy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G27637

G27637

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4415 La Salle Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 La Salle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Breuning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife: Anna V. Breuning
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1868

8. AGE: Years	Months	Days	If less than one day
76	7	23	hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: retired
11. Industry or business

FATHER
12. Name: Marcus Breuning
13. Birthplace: ?

MOTHER
14. Maiden Name: Catherine Rosemer
15. Birthplace: ?

16 (a) Informant: Mrs. Marie Sproll
(b) Address: 4415 La Salle Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road

APR 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that attended deceased from April 2nd 1945 to April 5 1945, and that I last saw him alive on April 5 1945.

Immediate cause of death	Duration
Lobar Pneumonia	4 days
Due to	
Due to	
Other Conditions Chronic hypertrophied disease	3 years

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Gordy M.D.

Address 5106 Harford Rd Date signed 4/6/45

VS 150

Dr. Bishop's Statement

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27638

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6201 Marietta Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6201 Marietta Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph R. Zink

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	marreid

6 (b) Name of husband or wife Catherine Zink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	26	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Installation Foreman
11. Industry or business Automatic Sprinkler Co.

FATHER
12. Name John Zink
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Julia Fischer
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Catherine Zink
(b) Address 6201 Marietta Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 4-7-1945 (Date rec'd by Registrar) Arrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to Apl 5 1945 and that I last saw h[illegible] alive on Apl 5 1945.

Immediate cause of death	Duration
Acute Myocarditis	1 day
Chron. Interstitial Nephritis	18 mo.
Due to Coronary Sclerosis	1944
Due to	
Other Conditions Acute Cardiac Failure	1945

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy W. Bishop M. D.
Address 501 S Kenwood Ave Date signed Apl 5

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

627639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Lemmon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 3
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Lemmon St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Hayes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mentina Hayes
6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1896

8. AGE: Years	Months	Days	If less than one day
49	1	6	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John Hayes
13. Birthplace Md.

MOTHER
14. Maiden Name Tottie Sampson
15. Birthplace Md

16 (a) Informant Mayie Muse
(b) Address 517 N Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1937 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) APR 7 1937 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1937, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1937, to April 5 1937, and that I last saw him alive on April 3 1937.

Immediate cause of death	Duration
Cardio Vascular Disease	2 mos
Due to Coronary Thrombosis	April 5
Due to Arteria Sclerosis	2 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1928 Penna Ave Date signed 4/6/37

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 627640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5263 Chapel Gate Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm H. Curry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Emma Curry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5- 1867

8. AGE: Years 78 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name — Curry
13. Birthplace Balto.

MOTHER 14. Maiden Name Elvina Slagsman
15. Birthplace Balto.

16 (a) Informant Ray. Curry
(b) Address 3704 Gibbons Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 9 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans st

19 (a) APR 7 1945 (Date received by Registrar) (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 4/5 1945 and that I last saw him alive on 19

Immediate cause of death	Duration
Acute Cardio-Vascular Collapse	2 days
Due to Arterio sclerosis General	
Due to	
Other Conditions Senile Dementia	7

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Gilmay P. Clarke M. D.
Address 336 Hilldale Rd. Signed

X

7641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Barnes St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Barnes St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Brady.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Margaret Brady

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3. 1871

8. AGE: Years 73 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer (Unemployed)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown.
15. Birthplace "

16 (a) Informant Mary Washington Daughter
(b) Address 817 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Robert L. Conway

(b) Address 801 N. Caroline St.

19 (a) APR 7 1945 (Date received by Registrar) (b) Huntington Wms Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to April 5 1945 and that I last saw h[illegible] alive on April 5 1945

Immediate cause of death Cardiac Failure

Due to Coronary insufficiency

Due to Syphilitic Carditis

Other Conditions Syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. K. Cadden M. D.

Address 2222 N. Caroline

Date signed 4-6-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G27642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G27642

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 ARUNAH AVE.
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 ARUNAH AVE.
(If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK MIELCKE

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 705-07-8881

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARIA-HOWARTH*
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) OCT. 11, 1881

8. AGE: Years 63 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business B & O RAIL ROAD

FATHER
12. Name Julius David MIELCKE
13. Birthplace GERMANY

MOTHER
14. Maiden Name JEANETTE BECK
15. Birthplace BALTIMORE, MD.

16 (a) Informant MARIA L. MIELCKE
(b) Address 2419 ARUNAH AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-9-45 (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK.
Location Woodlawn

18 (a) Funeral director G. LESTER WEBER
(b) Address 2503 EDMONDSON AVE.

19 (a) (Date rec'd by registrar) APR 7 - 1945 (b) Registered No. Waiting for Written MV

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945, at 7a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 19 to Apr 6 1945 and that I last saw h. alive on Apr 5 1945.

Immediate cause of death	Duration
Carcinoma Pancreas	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer C. Todd M. D.
Address 735 N. Fulton Av Date signed 4/6/45

G27643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27643

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N. Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lelar Hull

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9998

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Maggie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1880

8. AGE: Years	Months	Days	If less than one day
65	1		hr. min.

9. Birthplace Raleigh, N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Hull
13. Birthplace Raleigh, N. C.

MOTHER
14. Maiden Name Judy Comish
15. Birthplace Raleigh, N. C.

16 (a) Informant Mrs. Maggie Hull
(b) Address 511 N. Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 S Schroeder St

19 (a) (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

APR 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1945, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945, to 4/6 1945, and that I last saw him alive on 4/5 1945

Immediate cause of death Cerebral Apoplexy

Due to

Due to & Paralysis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Klutts M. D.
Address Date signed 4/6 1945

G27644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G27644

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6104 Old Washington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Hamilton Sr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Eliz Ellen Hamilton

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1869

8. AGE: Years	Months	Days	If less than one day
75	8	5	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Inspector (retired)

11. Industry or business Pullman Co.

FATHER
12. Name John Hamilton
13. Birthplace Ohio

MOTHER
14. Maiden Name Susan Cornell
15. Birthplace Ohio

16 (a) Informant Mrs. Eliza Ellen Hamilton
(b) Address 6104 Old Washington Rd., Elkridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location Wash. Blvd., Howard Co.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 7 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 45 19, at 11:50 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease.

Due to

Other Conditions Bronchopneumonia, Chronic nephritis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendes M.D.
Medical Examiner.
Date signed April 6, 1945.

VS 151

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G27645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 663

G2763

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive and 31st St.,

(c) Hospital or institution:
D.O.A. U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. J. (b) County

(c) City or town Cape May
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1120 New York Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore McWilliams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1942

8. AGE: Years	Months	Days	If less than one day
2	6	14	hr. min.

9. Birthplace Elizabeth City, N. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Lt. Theodore McWilliams
13. Birthplace Memphis, Tenn.

MOTHER
14. Maiden Name Nelly Sinclair
15. Birthplace Glouchester, Mass.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Cremation (b) Date thereof 4/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) APR 7 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-44 19..., to 3/29/45 19..., and that I last saw him alive on March 29, 1945

Immediate cause of death: Schuller-Christian disease — Duration: 10 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Benjamin F. Jones

Address US Marine Hospital Baltimore, Maryland Date signed 4/6/45

Approved by Howard J. Klumpp, M.D.

G27646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G27646

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 E. 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EPHRAM NELSON RITTASE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret Josephine Rittase

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 26, 1864

8. AGE: Years 81 | Months 0 | Days 10 | If less than one day hr. min.

9. Birthplace: Littlestown, Pa. (Town, county, and state)

10. Usual Occupation: Baker

11. Industry or business

FATHER
12. Name: Unknown Rittase
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. Elmer H. Rittase
(b) Address: 703 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

APR 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

Huntington Williams, M.D.

VS t50

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 6, 1945, at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/1945 to 4/6/1945 and that I last saw h— alive on 4/5/1945

	Duration
Immediate cause of death: Myocardial Insufficiency	about
Due to: Myocarditis	?
Due to: Generalized Arteriosclerosis	?
Other Conditions: Cardiac Asthma, Edema (Include pregnancy within 3 months of death)	6 days

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Thomas J. Mills, M. D.
Address 932 E 22nd St Date signed 4/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627647

WARNER B

627647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1226

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Maryland General Hospital

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County None

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1514 Bolton St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William F Wardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1905

8. AGE: Years 39 | Months 11 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Pressman

11. Industry or business News Post.

FATHER

12. Name Wm. F. Wardner, Sr.

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Margaret Dempsey

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mary W. Sullivan

(b) Address 226 Orange St. Mt. Clair

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto.

18 (a) Funeral director Wm. J. Dickener & Son

(b) Address Balto. Md.

19 (a) APR 7 - 1945 (Date rec'd by reg'r) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at 5 38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29/1945 to 4/5/1945 and that I last saw him alive on 4/5/1945

Immediate cause of death Intestinal obstruction

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 4 1945

Major findings of operation: dilatation of gastroenterostomy

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles C. Chandler M.D. M. D.

Address Md. Gen. Hosp. Date signed 4/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

527848
471637.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
56E

Registered No. 67848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 Church St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ralph W. Hunch.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-15

8. AGE: Years 29 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Minn. (Minneapolis) (Town, county, and state)

10. Usual Occupation Govt. Employee (Clerk)

11. Industry or business War Labor Board

FATHER 12. Name Ryoma A. Hunch

13. Birthplace N. D.

MOTHER 14. Maiden Name Priscilla Wilson

15. Birthplace Ill.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 7-1945 (month) (day) (year)

(c) Cemetery or crematory
Location Detroit, Mich.

18 (a) Funeral director Wm. J. Tickner & Sons.

(b) Address North & Penna Aves., Balto. Md.

19 (a) (Date rec'd by registrar) APR 7 1945 (b) Filed by Wilmer M.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6- 1945 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April-3 1945 to April-6 1945 and that I last saw him alive on April 6 1945.

Immediate cause of death Brain tumor — post operative. | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 4, 1945

Major findings of operation: Brain tumor - pituitary adenoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ewen W. Saunders

Address Bureau of the Budget Date signed 4/6/45

G27649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G27649

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Edgewood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Molair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife PATRICK McFAIN

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace GERMANY (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name FRED. HINES
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARIE HINES
15. Birthplace GERMANY

16 (a) Informant MR. HINES (BROTHER)
(b) Address 7610 CECIL AVENUE.

17 (a) Holy Redeemer Cem. (Burial, cremation, or removal) (b) Date thereof 4 · 9 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 504 E 32nd St

19 (a) APR 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1945, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were: probable

IMMEDIATE CAUSE OF DEATH Shock

Due to Internal Hemorrhages

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/5/45 at 6:30 A.M.
(b) Where did injury occur? 1629 E. Edgewood St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Fell off Porch Floor Porch

23. Signature C. P. Sulmirski M.D. Medical Examiner.

Date signed 4/6/45

627650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 627650

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Carolina & Eliza
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Fowler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Mary A. Donnelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Railroader

11. Industry or business Penna. R. R.

FATHER
12. Name Rudolf Fowler
13. Birthplace Maryland

MOTHER
14. Maiden Name —
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Fowler
(b) Address 2231 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave Balto. Md.

18 (a) Funeral director Harry H Whitla
(b) Address 4101 Edmondson Ave

19 (a) APR 7 - 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4- 1945, at 11 46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2- 1945, to 4-4 1945, and that I last saw him alive on 4-4 1945.

Immediate cause of death	Duration
Cardiac - respiratory failure.	
Due to Int - arachnoid hemorrhage.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Joseph's Hosp Date signed 4-4-45

VS 190

G27651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G27651

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 37 N. Belnord Avenue

(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 37 N. Belnord Avenue
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELENOR KASTNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Raymond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1900

8. AGE: Years 44 yrs. | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Mechanicsville, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John Murphy

13. Birthplace Mechanicsville, Md.

MOTHER

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Raymond Kastner

(b) Address 37 N. Belnord Avenue

17 (a) Burial (b) Date thereof 4/9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18 (a) Funeral director C. E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) (b) Huntington Williams Md.
(Date rec'd by registrar)

APR 7 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/45 19 , at 12:20 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1945 to 4/5 1945 and that I last saw h alive on 4/5 1945

Immediate cause of death	Duration
Chronic Laryngeal Tuberculosis	
Chronic Bilateral Pulmonary TB	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Leonard Stankowski M. D.

Address 2579 Eastern Ave. Date signed 4/6/45

X

627652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627652 131 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Bruce St 20
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days) 28

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Walter J. Stanis (Joseph J. Stanis)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-7703

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife Eva Stanis

6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) June 26, 1896

8. AGE: Years 48 | Months 9 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Brush maker

11. Industry or business ~~Wood Turning Co~~ Central Supplies Co.

FATHER 12. Name Anthony

13. Birthplace Lithuania

MOTHER 14. Maiden Name Marcianna Daniels

15. Birthplace Lithuania

16 (a) Informant Clara Chester

(b) Address 411 N Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 9 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road.

18 (a) Funeral director Charles W. Frushmaker

(b) Address 637 Washington Blvd.

19 (a) Date received by Registrar 1945 (Registrar's Signature) Huntington Williams M.D. Registrar

APR 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/45 19 ____ at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/45 to 4/5/45 19 ____; and that I last saw h[illegible] alive on 4/6/45 19 ____.

Immediate cause of death: Chronic Myocarditis + Arterio Sclerosis — Duration: Unknown

Due to: Chronic Nephritis — Unknown

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry C. Houston M.D.

Address 1929 W. Lanvale St. Date signed 4/7/45

X

627653 BALTIMORE CITY HEALTH DEPARTMENT ✓ 627653

CERTIFICATE OF DEATH 140D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4923 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4923 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Stackhouse

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1908

8. AGE: Years	Months	Days	If less than one day
38	3	0	hr. min.

9. Birthplace Millsville, Pa.
(Town, county, and state)

10. Usual Occupation Checker Shipyard

11. Industry or business

FATHER
12. Name Millard Stackhouse
13. Birthplace Pa.

MOTHER
14. Maiden Name Rose Lawton
15. Birthplace Pa.

16 (a) Informant Mr. Millard Stackhouse
(b) Address Bloomsburg Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/7/45 (month) (day) (year)
(c) Cemetery or crematory Bloomsburg Pa
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) APR 8 1945 (Date rec'd by registrar) (b) Huntington White Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at 9 22 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Air Embolism.
Dilatation of Cervix. Early
Gangrenous endometritis of
Due to
Other Conditions Pregnancy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 5 1945 ? M.
(b) Where did injury occur? Unknown
(c) Did injury occur at home, on farm, industrial place, in public place? ? While at work? ?
(d) Means of injury attempted Abortion

23. Signature Robert L. Gratton M.D.
Medical Examiner.
Date signed April 6 1945

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

627654 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Webb st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cleo Brody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Brody

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-98

8. AGE: Years 46 | Months 8 | Days 12 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name John Fillmore
13. Birthplace Pa.

MOTHER
14. Maiden Name Ida Cart
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 7-45 (month) (day) (year)

(c) Cemetery or crematory Red Lion
Location Red Lion Pa

18 (a) Funeral director William Cook Jones
(b) Address 1217 St Paul Street

19 (a) 4 APR 45 (Date rec'd by registrar) (b) Justin Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1945 at 7 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1945, to 4-7 1945, and that I last saw h alive on 4-7 1945.

Immediate cause of death: Adenocarcinoma ovary, right — Duration: ?4 months
Ascites + pleural effusion — 4
Due to Carcinoma metastases peritoneum + pleura. — 4
Due to — 10
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Pleural + peritoneal effusion
of autopsy: metastases peritoneum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David B. Check M.D.
Address Johns Hopkins Date signed 4-8-45

VS 150

X

627655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

X ✓ 627655 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Harvandstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-45

8. AGE: Years	Months	Days	If less than one day
	1	-	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George H. Adams

13. Birthplace West Virginia

MOTHER 14. Maiden Name Lucille Adams

15. Birthplace West Virginia

16 (a) Informant Parents

(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)

(c) Cemetery or crematory Needmore

Location Martinsburg W Va

18 (a) Funeral director E C Hebner & Sons

(b) Address Ellicott City Md

19 (a) [illegible] (Delivered by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945 to April 6 1945 and that I last saw h[illegible] alive on April 6 1945

Immediate cause of death	Duration
Operation for	
Due to repair of	
Due to omphalocoele	
Other Conditions ? Branchial cleft cyst	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Bermingham M.D.

Address JHH Date signed 4-7

X

G27656 Liv. Mem. 1938 Liber G276.56 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3505 W. Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Johnson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: the late James J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1878

8. AGE: Years 67 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name C. Friedel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary J. Wagner
15. Birthplace Germany

16 (a) Informant Ambrose Friedel
(b) Address Illchester, Md.

17 (a) Burial (b) Date thereof 4-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 8 - 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1945, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 22 1945 to Apl 7 1945, and that I last saw h[er] alive on Apl 6 1945

Immediate cause of death	Duration
1st stage Cerebral Hemorrhage	2/22/45
2nd Stroke	4/6/45
Due to Hypertension	Several Years
Due to Cardio-renal	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Brown M.D.
Address 1938 Linden Ave Date signed 4/7/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G27657 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Traxette T. Dukes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband William T. Dukes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1876

8. AGE: Years 69 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Cal.
(Town, county and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Michael Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Lintline
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Chas. Hanna
(b) Address 4709 Roland Ave

17 (a) Burial (b) Date thereof 4/9/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) 1945 (b) Registered by registrar Irington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1937 to Apr 6 1945 and that I last saw h.e. alive on Apr 2 1945

Immediate cause of death
Coronary Occlusion
Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Singley M.D.

Address 50 E. North Ave Date signed 4-6-45

TN. G27658 92938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G27658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 John St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Conrod Miller (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Hanager (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 4/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Wilkins Cook Inc
(b) Address 1217 St. Paul st.

19 (a) 1945 (b) Wilson M.B.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1945 19 , at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 19 45 to April 6 19 45 and that I last saw h im alive on April 6 19 45

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Cardio Pulmonary disease	
Due to	
Other Conditions Arterio-sclerotic Gangrene left foot (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Reuter M. D.
Address City Hosp. Date signed 4-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G27659

Registered No. 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Mill St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillips, Mc. Jerri.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25th 1867

8. AGE: Years	Months	Days	If less than one day
77	4	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W. Phillips.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Tennard
15. Birthplace Maryland

16 (a) Informant Record Church Home + Inf
(b) Address

17 (a) Removal (b) Date thereof 4/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Dorchester Memorial Park
Location Cambridge Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1945, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20 1945 to Apr. 7 1945 and that I last saw h alive on 4-7 1945.

Immediate cause of death	Duration
Acute peritonitis	16 hrs
Due to decomposition of an entero-enterostomy	
Due to for partial intestinal obstruction.	6 days
Other Conditions Carcinoma Sigmoid, recur. Fecal obstruction terminal	6 yrs

(Include pregnancy within 3 months of death)
Date of operation 4-3-45
Major findings of operation: Ca of Sigmoid recurrent, Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Ivan Hatch, M. D.
Address C. H. H. Date signed 4-7-45

X

G27660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G27660 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Nura St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Huber Baby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 30, 1945

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Sinai Hospital Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew L. Huber.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances L Allen.
15. Birthplace Georgia.

16 (a) Informant Mrs. Frances L. Huber.
(b) Address 2633 Nura Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director George J Ruth Inc.
(b) Address 1735 Harford Ave

19 (c) APR 8 1945 (Date received by registrar) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1945, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1945 to 4-7 1945, and that I last saw h[illegible] alive on 4-7 1945

Immediate cause of death	Duration
Pulmonary Embolism from Foetal.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Sinai Hospital Date signed 4/7

G27661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G27661

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Edward Pryor
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 4/24/1871

8. AGE: Years	Months	Days	If less than one day
70	11	12	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Horan
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Wyoming
15. Birthplace Ireland

16 (a) Informant Hosp. Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Monument
Location Loudon Park

18 (a) Funeral director J. J. Foley Sons
(b) Address 1320 Light St.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

APR 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/45 19 , at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 4/6 1945, and that I last saw her alive on 4/5 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Post operative depression	
Due to carcinoma of bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/2/45

Major findings of operation: Bladder stone; Ca. of bladder.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen A. Howe, M.D.

Address Johns Hopkins Hosp. Date signed 4/6/45

X

G27662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G27662

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green Spring & Belvedere

(c) Hospital or institution Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. Green Spring & Belvedere

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Freida Freed.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mordecia

13. Birthplace Russia

MOTHER 14. Maiden Name –

15. Birthplace Russia

16 (a) Informant Ida Speedy

(b) Address 3710 Wood Haven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-45 (month) (day) (year)

(c) Cemetery or crematory Baeth Hebrew

Location Belmont Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1459 E. Balto St

PR 8 1945

19 (a) (Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1942 to 4-7 1945, and that I last saw h[er] alive on 4-7 1945.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edmund Levin M. D.

Address Levindale Date signed 4/7/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157 B

G27663 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 407 N. Exeter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Exeter St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Richard Gene Hartolt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Infant
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) April 2-1945
8. AGE: Years — Months — Days 5 — If less than one day hr. — min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Oakley Hartolt.
13. Birthplace W Va.

MOTHER
14. Maiden Name Esthel Wilson
15. Birthplace Ohio.

16 (a) Informant Mr. Oakley Hartolt
(b) Address 407 N. Exeter St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto Md
18 (a) Funeral director Geo L. Bayer Jr
(b) Address 1512 Holliday St
19 (a) 4-8-1945 (Signature of registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945 at 1 00 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 7 1945, and that I last saw — alive on 4/7/ 1945.

Immediate cause of death
Due to Spinal Bifida — Duration 5 day
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature Milton J. Solomon
Address 129 S. Bway Date signed 4/12/45

627664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627664 ✓ 131a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4019 W Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. McCullough Sr.
3 (b) If veteran, name war ✓ 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Schlehorn 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1897

8. AGE: Years	Months	Days	If less than one day
47	9	1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Balto. City

FATHER
12. Name Harry C. McCullough
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth McCullough
(b) Address 4019 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3501 old Frederick Rd
18 (a) Funeral director Harry H. Hetzler
(b) Address 4101 E. Lexington Rd.
19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945, at 7 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 4/6 1945, and that I last saw him alive on 4/5 1945.

Immediate cause of death	Duration
Renal Insufficiency	2 mos
Due to Hypertensive Cardio-Vascular Renal Disease	1 year+
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thos E Ross M.D.
Address 3629 Edmondson Date signed 4/6/45

VS 150

X

627665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

627665

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 N. Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Bode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1891

8. AGE: Years 53 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER 12. Name Daniel Besany

13. Birthplace Austria

MOTHER 14. Maiden Name Ida Neugatauer

15. Birthplace –

16 (a) Informant Mr. Louis C. Bode

(b) Address 509 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn Md.

18 (a) Funeral director Hardy & Wittstadt

(b) Address 4101 Edmondson Ave

19 (a) [illegible] (Filed rec'd by registrar) (b) Washington [illegible] (Signature of registrar)

APR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1937, to 4/5 1945, and that I last saw her alive on 4/5 1945

Immediate cause of death: Generalized Metastatis Cystitis — Duration 4 mo

Due to Carcinoma of breast — 2 mo

Due to — 8 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Klimes

Address 2623 E. Monument Date signed 4/6/45 M.D.

VS 150

X

G27666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27666 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 Ballou Ct
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 Ballou Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. James L. Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1882

8. AGE: Years 63 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Med Doctor

11. Industry or business Self.

FATHER 12. Name James E. Montgomery

13. Birthplace ?

MOTHER 14. Maiden Name Virginia Brooks.

15. Birthplace ?

16 (a) Informant Lillie Montgomery

(b) Address 237 Ballou Crt

17 (a) Removal (b) Date thereof 4/8/45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Elkins W. Va.

Location W. Va.

18 (a) Funeral director Wm Cook Inc.

(b) Address 1217 St Paul St

APR 8 1945 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1945, 10.00 P.M.

21. I certify that I took charge of the remains described above, held an Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Arteriosclerotic Cardiovascular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 4/7/45.

627667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B Registered No. 627667

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ Va. (b) County
(c) City or town So Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Stubbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-28

8. AGE: Years 16 Months 8 Days 25 If less than one day hr. min.

9. Birthplace Canada (town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Louis Stubbs
13. Birthplace England.

MOTHER 14. Maiden Name Katherine Brandle
15. Birthplace Ga.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof April 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Geo Wash Mem.
Location

18 (a) Funeral director J. Arthur Walters
(b) Address 25 S Carroll St Md Wash. D.C.

19 (a) [illegible] by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945 at 7 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1945 to Apr 7 1945 and that I last saw h[illegible] alive on April 7 1945.

	Duration
Immediate cause of death Fecal abscess and fecal fistula	1 mo
Due to Paralytic Peritonitis	6 mo.
Due to Perforation Strangulated ileum	6 mo.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/26/45

Major findings of operation: Post operative adhesions

of autopsy: above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Longmire Jr.
Address Johns Hopkins Hosp Date signed 4/13/45

VS 150

627668 ✓ 627668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 N. Carey
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. LeMuth (LEHMUTH)

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-7624

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Mary M. LeMuth
6 (c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) Jan 24-1890
8. AGE: Years 55 | Months 2 | Days 14 | If less than one day — hr. — min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Candy Maker
11. Industry or business

FATHER
12. Name Louis Wm LeMuth
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lillian Evans
15. Birthplace Balto Md.

16 (a) Informant Mary LeMuth
(b) Address 237 N. Carey St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location: Baltimore Md

18 (a) Funeral director J. W. Albert Sons
(b) Address 618 St. Baltimore, Md

19 (a) APR 9 - 1945 (To be filled in by Registrar) (b) Registrar Washington Wilkinson, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1945, to April 8 1945, and that I last saw him alive on April 7 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arterio-Sclerosis	
Due to Secondary Hypertension	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Bernard T. Francis
Address 2329 Arunah Ave Date signed 4/9/45

G27669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G27669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2732 Mura St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hanora A. Miller

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 216-01-5205

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1884

8. AGE: Years 60 | Months 5-7 | Days 6 | 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Candy Packer
11. Industry or business Virginia Dare

FATHER
12. Name George Miller
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Johanna Foley
15. Birthplace Balto. Md.

16 (a) Informant Robert R. Miller
(b) Address 1126 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 9/45 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director Fred. A. Kranz & Son
(b) Address 2210 E. Chase St.

19 (a) APR 9 1945 (b)
(When received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to April 6 1945, and that I last saw her alive on April 6 1945.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Or Coronary arteriosclerosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pakorny M.D. M. D.
Address 2200 E. Madison St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 180

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27670 G27670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., days) 21
(e) Length of stay in Baltimore (yrs., mos., days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Joseph H Sacks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs Rose Sacks

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): March 17 1867

8. AGE: Years 78 Months 21 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Retired Merchant

11. Industry or business: Retail grocery

FATHER
12. Name: Harry Sacks
13. Birthplace: Russia

MOTHER
14. Maiden Name: Tobia
15. Birthplace: Russia

16 (a) Informant: Mrs Rose Sacks
(b) Address: 1640 Gwynn Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 9 1945 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale
Location: Harford ave Philadelphia Rd

18 (a) Funeral director: Jos Levinson & Bros
(b) Address: 1124-26 E. North ave

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 150

APR 9 - 1945 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/8 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1945 to 4/8 1945, and that I last saw him alive on 4/8 1945

Immediate cause of death	Duration
Resp. failure	
Due to Uremia - Arteriosclerosis	
C - V - Dis = Hypertension	
Due to	
Other Conditions Prostatic obstruction	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry J Rogers M.D.
Address: Mercy Hosp. Date signed 4/8/45

G27671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G27671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2114 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Woodyear St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Annie D. Schlotthober

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12- 1876

8. AGE: Years 68 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Henry Schaffer

13. Birthplace Unknown

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Edwin Schlotthober

(b) Address 307 S. Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-1945 (month) (day) (year)

(c) Cemetery or crematory Western City

Location

18 (a) Funeral director Robt C. & B.M. Walters

(b) Address 1411 Stricker Sts

19 (a) Filed APR 9 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1945, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1942 to April 6 1945 and that I last saw her alive on April 5 1945

Immediate cause of death: Cancer of Breast — Duration 2 yrs

Due to: Arteriosclerotic Heart — 4 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Israel Rosen M. D.

Address 2413 E Monument St Date signed X 4/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NAMES RESERVED FOR BINDING

G27672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27672 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ###
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Laucht

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H. Laucht

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March 6, 1887

8. AGE: Years 58 | Months 1 | Days 2 | If less than one day ....hr. ....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name James F. Heywood
13. Birthplace England

MOTHER
14. Maiden Name Mary E. Taylor
15. Birthplace Worcester CO. Md.

16 (a) Informant John H. Lauch
(b) Address 2914 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) APR 9 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 8 - 1945 19.... at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 26 1945 to Apr 8 1945 and that I last saw h[illegible] alive on Apr 8 1945

Immediate cause of death: Chronic Cardiac Vas Lesions — Duration

Due to:

Due to:

Other Conditions: Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emma A. Laucht

Address 1735 Pop St Date signed 4/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27673 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 N.Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3247 Shannan Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F.Frizzell

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna M.Frizzell

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec. 15,1881

8. AGE: Years	Months	Days	If less than one day
63	3	22	....hr. ....min.

9. Birthplace Woodlawn Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Alfred W.Frizzell
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Eleonor Bollinger
15. Birthplace Penna.

16 (a) Informant Mrs. Anna M.Frizzell
(b) Address 3247 Shannon Drive

17 (a) Burial (b) Date thereof April 10,1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Co. Md.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 (a) APR 9 - 1945 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945, at 9:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 7 19 45 to APRIL 7 19 45 and that I last saw h/m alive on APRIL 7 19 45

Immediate cause of death CORONARY THROMBOSIS — Duration 1 DAY

Due to

Due to

Other Conditions ACUTE MYOCARDIAL INFARCTION — 1 DAY
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Kavanaugh M.D.

Address 326 N. Calvert St. Date signed 4-8-45
M. D.

Affirmed by Howard J. Thomsen, M.D.

G27674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G27674 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Broadway
(b) Street address 119 S. Fremont
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 East Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary P. Fowler

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife LeRoy J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1913

8. AGE: Years 31 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Denton, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John J. Cohee
13. Birthplace Denton Md.

MOTHER 14. Maiden Name Anna Gouatt
15. Birthplace Denton, Md.

16 (a) Informant John C. Waldeck
(b) Address 4300 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Denton Cem
Location Denton Md.

18 (a) Funeral director Wm. Cook Jno.
(b) Address 1217 St Paul St.

19 (a) Registered by (b) Apr 9 1945 Huntingtow W Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/45 19, at 12:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to

Other Conditions 3rd & 4th ° Burns

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 2/1
(a) Date of injury 4/8/45 12:01 A.M.
(b) Where did injury occur? Home - 2003 E. Fairmount
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Exploding Oil Stove

23. Signature John A Davis M.D. Medical Examiner.
Date signed 4/8/45

X

G27675 ✓ G27675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.....

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6217 Biltmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6217 Biltmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Ross

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 10, 1876

8. AGE: Years 68 | Months 7 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Andrew Hoofnagle
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth Donahue
15. Birthplace: Baltimore, Md.

16 (a) Informant: Miss Ella B. Hoofnagle
(b) Address: 6217 Biltmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS APR 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 3 45/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1943 to April 8 1945.
and that I last saw h.... alive on April 7 1945.

Immediate cause of death	Duration
Hypertensive Heart Disease	10 yrs
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 878 W 36th St Date signed April 9/45

X

47278 — 47276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57

Registered No. G27675

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4122 Durnall Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Weber

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-7795

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret B.
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 12-27-92

8. AGE: Years	Months	Days	If less than one day
52	3	9	hr. min.

9. Birthplace Savannah Ga.
(Town, county, and state)
10. Usual Occupation Public accountant
11. Industry or business

FATHER
12. Name William Weber
13. Birthplace Cumberland Md.

MOTHER
14. Maiden Name Annie Berry.
15. Birthplace Wilmington Del

16 (a) Informant Brenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 4/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Churchville Va.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (b) Huntington for Williams, M.D.
Registrar

APR 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1945 to April 6 1945, and that I last saw him alive on April 6 1945.

Immediate cause of death Brain Tumor — post operative.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/28, 4/6

Major findings of operation: Brain tumor — in frontal lobe, R. H. parietal-ventricle.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul W. Chambers M.D.
Address Johns Hopkins Hospital Date signed 4/7/45
M. D.

X

G27677 ✓ G27677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 Kennedy Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2023 Kennedy Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM JACOB FONSHELL

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Fonshell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1900

8. AGE: Years 44 | Months 10 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Ass't. Supt.

11. Industry or business Prudential Life Ins. Co.

FATHER
12. Name William J. Fonshell
13. Birthplace Middletown

MOTHER
14. Maiden Name Cecelia Gannon
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Margaret E. Fonshell
(b) Address 2023 Kennedy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 9 - 1945 (Date rec'd by Registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945 at 11:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 17 1944 to April 5 1945.
and that I last saw h~~im~~ alive on April 5 1945.

Immediate cause of death: Coronary Artery Thrombosis — Duration: 3 months
Due to: Arterial Hypertension — 10 Days, 1 year
Due to:
Other Conditions: Myocarditis — 1 year

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg
Address 2052 Kentucky Ave Date signed 4-9-45 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G27678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Gwynn Falls Pky
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Gwynn Falls Pky
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza A. Gautt

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3. 1864

8. AGE: Years 81 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace La Fargeville N.Y. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frederick A. Webb
13. Birthplace N.Y.

MOTHER
14. Maiden Name Rosa E. Cushman
15. Birthplace N.Y.

16 (a) Informant Mrs. Clara Murray
(b) Address 3 205 Gwynn Falls Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) APR 9 1945 (Date rec'd by registrar) (b) Huntington Hilliard registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 6 1945 at 1157 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 4 1945 to 4-6 1945 and that I last saw her alive on 4 - 6 1945

Immediate cause of death: Broncho - Pneumonia — Duration 4/4/45
Due to: Arterio-Sclerotic Cardio - Vascular Disease — 5yr
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Laukaitis, M.D.
Address 629 Washington Blvd Date signed 4/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

627679 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland Ave.
(c) Hospital or institution: West Balto. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Ramsay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMIL C. T. HAEFNER

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Minna Anna Haefner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1873

8. AGE: Years	Months	Days	If less than one day
71	5	7	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired Cleaner
11. Industry or business T. V. Susenmihl

FATHER
12. Name August Haefner
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Jacobin
15. Birthplace Germany

16 (a) Informant Mrs. Minna Anna Haefner
(b) Address 2009 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SON
(b) Address Balto., Md.

19 (a) (Make out in duplicate) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1945 at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1945 to 4/6 1945
and that I last saw him alive on 4/6 1945

Immediate cause of death Coronary thrombosis

	Duration
Due to	
Due to	
Other Conditions Hypertension Cardio-vascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Lehmpfuhl M. D.
Address West Balto. G. H. Date signed 4/6/45

VS 150

G27650

BALTIMORE CITY HEALTH DEPARTMENT ✓ 93D G27650

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4811 Laurel Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4811 Laurel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE EVANS SUTTON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary S. Sutton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1864

8. AGE: Years	Months	Days	If less than one day
80	5	14	hr. min.

9. Birthplace: Kent Co., Md. (Town, county, and state)
10. Usual Occupation: Cashier (retired)
11. Industry or business: Sherwood

FATHER
12. Name: Edward Sutton
13. Birthplace: Kent. Co., Md.

MOTHER
14. Maiden Name: Frances Callendar
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Mary Sutton
(b) Address: 4811 Laurel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) APR 9 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945 at 10:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 11 1945 to Apr 5 1945 and that I last saw h[illegible] alive on Apr 5 1945

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H N Pearce M. D.
Address: 2105 Eutaw Date signed: Apr 7/45

627681 BALTIMORE CITY HEALTH DEPARTMENT 627681
CERTIFICATE OF DEATH 94 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dunedin St
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Forest Park Avenue (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN SHEFFER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John William Sheffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/1872

8. AGE: Years 72 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name George H. Knight
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Rose Cane
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Ada M. McLaughlin
(b) Address 3909 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 9 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1945 at 9:06 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 4/7/45

VS 151

G27682 ✓ G27682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4304 Granada Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Granada Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl M. Horn

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-2257

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marian E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 1892

8. AGE: Years 53 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation Printer & Publisher

11. Industry or business

FATHER
12. Name John H. Horn
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary E. Heyn
15. Birthplace Harford Co. Md.

16 (a) Informant Mr. Kemp Horn
(b) Address 4304 Granada Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945, to April 8 1945, and that I last saw him alive on April 8 1945.

Immediate cause of death: Myocardial Insufficiency — Duration: 6 days

Due to:

Due to Nephritis — 6 Months

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J Davis M. D.
Address 800 W 33rd St Date signed 4-8-45

X

G27683 ✓ G27683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] + Calvert
(c) Hospital or institution: Union Memorial Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Urban Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George Adam Klotz

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: ~~M~~ Widowed
6 (b) Name of husband or wife: Julia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-21-1873
8. AGE: Years 72 | Months 1 | Days 16 | If less than one day ... hr. ... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Charles F. Klotz
13. Birthplace Penn.

MOTHER
14. Maiden Name Mary Grossman
15. Birthplace Penn.

16 (a) Informant Self.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn Md.
18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves
19 (a) (Date rec'd by Registrar) APR 9 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7- 1945, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1945, to 4-7 1945 and that I last saw h[illegible] alive on 4-7 1945

Immediate cause of death Cardio-Respiratory failure — Duration
Due to Toxemia
Due to Jaundice ? unknown Cause
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 4-2-45
Major findings of operation: nodules in liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Gore M. D.
Address Union Memorial Hosp. Date signed 4-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

627684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. 627684

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 WARNER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 WARNER ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA RODLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: BERNHARD RODLER

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JUNE 24-1878

8. AGE: Years 66 | Months 9 | Days 14 | If less than one day 13 hr. min.

9. Birthplace GERMANY. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant MRS EMMA COALE
(b) Address 1208 WARNER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-10-45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTO MD

18 (a) Funeral director Bernard C Hart
(b) Address 121 E West St

19 (a) APR 9 - 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/45 1945, to 4/7 1945, and that I last saw h[illegible] alive on 4/7 1945

Immediate cause of death Hemorrhage — Duration 24 hrs

Due to myocarditis — 1 year

Due to Hypertension — 2 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Poulton M.D.
Address 3909 Gamon Blvd Date signed 4/7/45

VS 150

G27685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27685 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5600 Park Heights Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 Park Heights Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Fannie Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24-1870

8. AGE: Years 75 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Henry Young
13. Birthplace Europe

MOTHER
14. Maiden Name Barbara Ott
15. Birthplace Germany

16 (a) Informant Mrs. Fannie Young
(b) Address 5600 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) APR 9 1945 Hunting Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7- 1945, at 11-15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1943 to Apr 7 1945 and that I last saw him alive on Apr 7 1945.

Immediate cause of death

Cerebral Softening — Duration 1943
Due to Arteriosclerosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm D. Burbett M. D.
Address 4603 Park Heights Ave Date signed 4/9/45

G27686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

G27686 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address... Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Orleans st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty J. Dawson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 18 1945

8. AGE: Years | Months | Days: 27 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Dawson

13. Birthplace Va.

MOTHER 14. Maiden Name Juanita Parks

15. Birthplace Va

16 (a) Informant Mrs. Juanita Dawson

(b) Address 1918 Orleans st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 9 45 (month) (day) (year)

(c) Cemetery or crematory

Location Lancaster Va.

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans st.

19 (a) Date received APR 9 1945 Huntington Williams, M.D. Registrar

VS-180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 1120 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 19 45 to April 9 19 45, and that I last saw h[illegible] alive on 19

Immediate cause of death Resp Failure

Due to

Due to

Other Conditions { Prematurity / Diarrhea

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brown, M.D.

Address Penna blvd Date signed 4/9/45

X

G27687

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G27687 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 McCulloh Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 McCulloh Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Camper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1875

8. AGE: Years 70 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Eastern Shore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Dennis Carey
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Elizabeth Stanley
15. Birthplace Eastern Shore, Md.

16 (a) Informant Minnie Butler
(b) Address 1706 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Wm. Georg W. Hubbard
(b) Address 1631 Druid Hill Ave

19 (a) APR 9 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1945, at 10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Contusions

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Meredith M.D.
Medical Examiner.
Date signed April 6, 1945.

G27688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27688

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County.....
(c) City or town Delta
(If outside city or town limits, write RURAL and give town)
(d) Street No. R F D #1
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Wilson Barben

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 14, 1914

8. AGE: Years	Months	Days	If less than one day
30 31	1	24	....hr. ....min.

9. Birthplace HARFORD Co. MD.
(Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business

FATHER
12. Name HARRY M. BARBEN
13. Birthplace YORK Co., PA.

MOTHER
14. Maiden Name DORA M. THOMPSON
15. Birthplace HARFORD Co. MD.

16 (a) Informant HARRY M. BARBEN
(b) Address DELTA, PA., R.D.

17 (a) Burial (b) Date thereof Apr 11 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location Delta, Pa.

18 (a) Funeral director Hubert P. Hoffman
(b) Address Delta Pa.

19 (a) APR 9 - 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1945, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull.

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 8, 1945 3:30 P.M.
(b) Where did injury occur? McDonough, Md
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury auto ran off road.

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 4/8/45

VS 151

G27689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. G27689

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William G. Allen.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary R. Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1885

8. AGE: Years: 59 | Months: 7 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: Benjamin Coates Allen
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Ella Coates
15. Birthplace: Baltimore Md

16 (a) Informant: Mrs. Mary Allen
(b) Address: 910 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: MARTIN FAHEY & SONS
(b) Address: 1827 W. North Ave.

19 APR 9 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2/45 19 , to 4/8/45 19 , and that I last saw him alive on 4/8/45 19

Immediate cause of death	Duration
Congestive Heart failure and Pneumonia	4 days
Due to Coronary disease	?
Due to	
Other Conditions peptic ulcer	

(Include pregnancy within 3 months of death)

Date of operation 4/4/45
Major findings of operation: peptic ulcer
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grayson S. Waldrop M.D.
Address Bon Secours Hospital Date signed 4/8/45

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 627690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1949 W. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGH H. KLAGES

3 (b) If veteran, name war: --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Almira V. Klages
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business R. G. Dunn & Co.

FATHER
12. Name Frederick Klages
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jane Houston
15. Birthplace Ireland

16 (a) Informant Mrs. Almira V. Klages
(b) Address 1949 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 4/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 9 - 1945 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1945, at 1:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Apl 6 1945, and that I last saw him alive on Apl 6 1945.

Immediate cause of death	Duration
Sarcoma Skull	4 mo
Sarcoma of Carotid Sheath	3 mo
Sarcoma of Lung.	
Due to Cardiac Asthma	2 da
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. M. Tondreau M.D.
Address 1202 St Paul St Date signed 4/9/45

VS 150

G27691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1342

Registered No. G27691

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument st & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 704 Newington Ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Benjamin Rabenowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Peddler

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery

Location Butler Corbin St

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

APR 9 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 4/6 1945, and that I last saw him alive on 4/6 1945.

Immediate cause of death Uremia — Duration

Due to Kidney disease

Due to

Other Conditions Cardiac Dilatation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Kidney stones + prostatic hypertrophy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 4/8/45

G27692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

Registered No. G27692

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Ave + Dickeyville St.
(c) Hospital or institution West Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patience Parsley

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1866

8. AGE: Years 79 | Months — | Days 24 | If less than one day hr. min.

9. Birthplace Ellenelg Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Dress making

11. Industry or business

FATHER 12. Name James L. Parsley
13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Brandenburg
15. Birthplace Maryland

16 (a) Informant Mrs John W. Rine
(b) Address 3411 Edmondson Ave

17 (a) Burial (b) Date thereof Apr. 10, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Kenydee
Location near Cooksville

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

APR 9 — 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/45 19 , at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7/45 19 to 4/7/45 19 , and that I last saw h alive on 4/7/45 19

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Oedema	
Due to Burns 1° 2° 3°	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4/7/45 about 10 A.M
(c) Where did injury occur? Home Balto City
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Burns from Stove

23. Signature James A. Rinker
Address West Balto Gen. Date signed 4/7/45

VS 150

Approved 4/9/45 Hugh B. McNally M.D. per Robert Lee Eustace M.D.

G27693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27693 / 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Ellsworth
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Ellsworth
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Henry

3 (b) If veteran, name war: 2
3 (c) Social Security Account No.: 1

4. Sex: M
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age , years

7. Birth date of deceased (mo., day, yr.) Nov 15 1877

8. AGE: Years	Months	Days	If less than one day
68 . 67	4	20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation ? Laborer
11. Industry or business

FATHER
12. Name Samuel Henry
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Henry
15. Birthplace Va

16 (a) Informant Sadie Henry
(b) Address 1634 Ellsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 9 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

APR 9 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 8:16 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis, M.D.
Medical Examiner.
Date signed 4/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G27694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Preston St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) FULL NAME (Baby) Mark Noble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1944

8. AGE: Years | Months: 6 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Mark Noble
13. Birthplace D. C.

MOTHER
14. Maiden Name Ophelia Perkins
15. Birthplace Balto., Md.

16 (a) Informant Ophelia Perkins
(b) Address 307 Preston St.

17 (a) Burial (b) Date thereof (burial, cremation, or removal) Apr. 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Mt Cem

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 APR 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 7 35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1945, to 4/5 1945, and that I last saw him alive on 4/5 1945.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius S. White

Address Provident Hospital Date signed 4/6/45

X

G27695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

G27695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 S. Bouldin ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 S. Bouldin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Hinterberger

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-9142

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1893

8. AGE: Years	Months	Days	If less than one day
51	7	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Hinterberger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Koran
15. Birthplace Germany

16 (a) Informant Caroline Hinterberger
(b) Address 813 S. Bouedin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month), (day), (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly + Zaden Co
(b) Address 403 S. Wolfe St.

19 (a) APR 9 - 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 6 20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage due to Hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 9 1945 6 A.M.
(b) Where did injury occur? 813 S Bouldin St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Hanged Self

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed April 9 1945

G27696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27696 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Longwood Ave. & Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Madeley Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Madeley

3 (a) FULL NAME William S. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie E. Wood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1885

8. AGE: Years	Months	Days	If less than one day
59	3	10	hr. min.

9. Birthplace Jersey City N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. S. Williams
13. Birthplace

MOTHER
14. Maiden Name Louise Murphy
15. Birthplace

16 (a) Informant Mrs Marie E. Williams
(b) Address 2709 Madeley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-45 (month) (day) (year)
(c) Cemetery or crematory Woodland Pk
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Reisterstown Rd.

19 (a) 1-00-0 (Date received by registrar) (b) Washington Williams M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945 to April 7 1945, and that I last saw him alive on April 2 1945.

	Duration
Immediate cause of death Coronary thrombosis cerebral infarction (Final event)	
Due to Hypertension Cardiac vascular disease	
Due to	
Other Conditions Congestive Cardiac failure; Pleural effusion (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation: Coronary occlusion, Arteriosclerosis & Pulmonary

of autopsy: with infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm S. McBarnum M. D.
Address West Baltimore General Hos. Date signed 4-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G27697 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5103 Golden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Ernest Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Nora V. (Clifford)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-1892

8. AGE: Years	Months	Days	If less than one day
53	-	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER 12. Name Geo W Hall
13. Birthplace Md

MOTHER 14. Maiden Name Mary M. Brewell
15. Birthplace Md

16 (a) Informant Mrs Nora V. Hall
(b) Address 5103 Golden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-45 (month) (day) (year)
(c) Cemetery or crematory Woodland Pk
Location Baltimore

18 (a) Funeral director Leonard J. Finch
(b) Address 5206 Harford Rd

19 (a) [illegible] 0 - 1945 (Date rec'd by registrar) (b) Courtney Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1945, at 6-29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1945, to 4-7 1945, and that I last saw h. l. alive on 4-7 1945

Immediate cause of death	Duration
Cardio Respiratory Failure	
Dehydration & Exhaustion - Carcinoma of Stomach	
Due to Pneumonia, Contributory	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-22-45
Major findings of operation: Ca of Stomach & metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. McFadden M. D.
Address St Joseph Hosp Date signed 4/7/45

VS 150

G27698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G27698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD SULLIVAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/40

8. AGE: Years	Months	Days	If less than one day
5	4	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER
12. Name Morton Sullivan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellwood O'obrien
15. Birthplace North Carolina.

16 (a) Informant Father.
(b) Address 918 Druid Hill Ave.

17 (a) Burial (b) Date thereof 4-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location R. C. Sec.

18 (a) Funeral director Sam. M. Sullivan Jr.
(b) Address 417 N. Carrollton Ave.

19 APR 9 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1945, to 4/8 1945, and that I last saw h~~e~~ alive on 4/8 1945.

Immediate cause of death: respiratory failure — Duration

Due to: meningitis

Due to: probable tuberculosis

Other Conditions: pulmonary tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed

X

G27699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

148a

G27699 Registered No. 118198

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eaton + Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 100 Osborne Ave
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: Mrs (Anne) Mc Donald Anna F.

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Julian widowed

6 (b) Name of husband or wife: Julian W Mac Donald

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1893

8. AGE: Years: 51 | Months: 50 | Days: 3 | If less than one day: hr. 15 min.

9. Birthplace: Mckeesport (Town, county, and state)

10. Usual Occupation: Home work

11. Industry or business:

FATHER
12. Name: Matthew Frame
13. Birthplace: Mckeesport

MOTHER
14. Maiden Name: Mckeesport
15. Birthplace: Mckeesport

16 (a) Informant: Mr. G. P. Carsley
(b) Address: 100 Osborne Ave Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 9, 1945 (month) (day) (year)
(c) Cemetery or crematory: Pine Grove Cem.
Location: Sand Spring Rd. St. Marie Church

18 (a) Funeral director: Charles E. Delozier
(b) Address: Ellicott City Md.

19 (a) APR 9 - 1945 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL - 9 - 1945 at 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 12 - 1944, to 4 - 9 - 1945, and that I last saw her alive on 4 - 9 - 1945.

	Duration
Immediate cause of death: Circulatory collapse	
Due to: Carcinoma of cervix	
Due to: Metastases	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Jose A Alvarez de Chaudens M. D.
Address: Date signed:

VS 150

X

G27700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G27700 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 St. Paul Street
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) -----
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 St. Paul Street (If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Markoe Dugan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hammond J. Dugan

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) April 23, 1872

8. AGE: Years 72 | Months 11 | Days 15 | If less than one day -- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -----

FATHER
12. Name: Col. Frank Markoe
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden Name: Maria Perry Thomas
15. Birthplace: Easton, Maryland

16 (a) Informant: C. Nelson Dugan
(b) Address: 520 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) APR 9 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1945; at 3:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan'y 1st 1945; to April 8th 1945, and that I last saw h-- alive on April 8th 1945

Immediate cause of death: Myocardial Insufficiency — Duration: 6 months
Due to: Chronic Nephritis — 1 year
Due to: Arteriosclerosis — 5 years
Due to: Hypertension — 8 years
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: ---
Major findings of operation:
of autopsy: ---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. A. Cleveland M. D.
Address: 1300 N. Calvert St Date signed: April 9/45

X

G27701 G27701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Balto. Gen. Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 N. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Beckett

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown.
15. Birthplace "

16 (a) Informant Hazel Preston
(b) Address 850 S. Eutaw St.

17 (a) Burial (b) Date thereof 4-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brandt Ley Ave

19 (a) (Date rec'd by registrar) (b) Harrington Williams, Registrar

APR 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6- 1945, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia

Due to

Other Conditions Hyfor trophy of Prostate.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-7-45

VS 151

G27702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27702 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 E Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John R. Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1887

8. AGE: Years 58 | Months 3 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Town, county and state)

10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Charles Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Flemmidge
15. Birthplace Va

16 (a) Informant Fannie Brown
(b) Address 1410 E Chase St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 10/45 (month) (day) (year)
(c) Cemetery or crematory
Location Shallowell Virginia

18 (a) Funeral director Mrs. Edred A. Elliott
(b) Address 1129 N. Caroline St.

APR 9 - 1945 Date received by Registrar Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945 at 6.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 8, 1944, to April 7, 1945 and that I last saw him alive on 4-6-1945

Immediate cause of death	Duration
Cardio-renal	
disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1422 E. Chase Date signed 4-10-45

VS 150

G27703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-40

Registered No. G27703

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Abell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Forest Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Ernest Minnich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herman W. Minnich

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1910

8. AGE: Years 34 | Months 5 4 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Forest Hill (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Wm James Norris

13. Birthplace Harford Co

MOTHER 14. Maiden Name Sarah Elz. Daughtee

15. Birthplace Harford Co.

16 (a) Informant Reginald N. Woodburn

(b) Address 323 E Universal Pl Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/45 (month) (day) (year)

(c) Cemetery or crematory Chestnut Hill

Location Harford Co, Md

18 (a) Funeral director James F. Fahey

(b) Address Belair, Md.

19 APR 10 1945 (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/43 19__ to April 9 1945, and that I last saw h__ alive on April 9 1945

Immediate cause of death Brain tumor (Glioma) — Duration

Due to malignant

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan. 4 1944

Major findings of operation: Brain tumor

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Bagley, Jr. M. D.

Address Latrobe Apts. Date signed

G27704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 ✓

Registered No. G27704

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 181
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 9 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Holton Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Thomas J Harden Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mary Matilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 29th 1873

8. AGE: Years 71 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Road Contractor

FATHER
12. Name: Thos. Jenkins Harden Sr.
13. Birthplace: Howard Co. Md.

MOTHER
14. Maiden Name: Ann Jackson
15. Birthplace: Balto. Md.

16 (a) Informant: Anna Russell
(b) Address: 4222 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: London Park
Location: Balto Md

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 E. Paul St.

19 (a) APR 10 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1945, at 9 ✓ AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert C. Graham M.D.
Medical Examiner.
Date signed April 9 1945

G27705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G27705

T. 92318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 11
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2959 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Abrisch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife No Record

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11th 1879

8. AGE: Years 65 | Months 3 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Milton Farms Dairy

FATHER
12. Name Jacob Abrisch
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Jane Horton
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 4/10/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 E. Paul St.

19 APR 10 1945 (b) Huntington Williams MD
(Date received by local registrar) (Signature of local registrar)

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important. MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th, 1945 19 ..., at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2nd 1945 to April 6 1945, and that I last saw him alive on April 6 1945

Immediate cause of death: Coronary Occlusion — Duration: No Record

Due to: Arteriosclerotic Heart Disease — 7

Due to: — 2 Mos.

Other Conditions: Congestive Heart failure
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 4-9-45
M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

Registered No. 627706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 N. Chester st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Chester st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Wall

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or~~ divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Bertha Wall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16th 1882

8. AGE: Years	Months	Days	If less than one day
62	11	22	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business machinist

FATHER
12. Name Martin Wall
13. Birthplace Poland

MOTHER
14. Maiden Name Rozine ?
15. Birthplace

16 (a) Informant Bertha Wall
(b) Address 507 N. Chester st.

17 (a) Burial (b) Date thereof 4/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) APR 10 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1945, at 8.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to April 8 1945
and that I last saw h alive on 19

Immediate cause of death	Duration
Myocardial failure	
Due to Chronic endocarditis & Pneumonitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature N. R. Brownlee M. D.
Address 1125 St Paul St Date signed 5/9/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186A

Registered No. G27707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution Mpl. Hosp. Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 Brayton Rd
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carolyn Whitehead

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ James N.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) about 1858

AGE: Years 87 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John B. Gutman
13. Birthplace At Home

MOTHER
14. Maiden Name Dorothea Pohlman
15. Birthplace Unknown

16 (a) Informant Mrs. Wm Poole
(b) Address 326 Brayton Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

APR 10 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 2.30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8 1945 to Apr. 9 1945 and that I last saw h[illegible] alive on Apr. 9 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension & Arteriosclerosis	
Due to	
Other Conditions Fractured humerus right (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Jan. 8 1945 7 P M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fell and struck floor

23. Signature L.T. McCormack M. D.
Address M.H.H. Date signed 4-9-45

Approved: Robert Lee Gutman M.D. 4/9/45

G67708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

Registered No. G67708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town St. Denis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Sutton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Forgan Sandman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph Sandman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1892

8. AGE: Years	Months	Days	If less than one day
52	7	10	hr. min.

9. Birthplace Relay, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business Bendix Radio

FATHER
12. Name David T. Forgan
13. Birthplace Edinboroûgh, Scotland

MOTHER
14. Maiden Name Charlotte King
15. Birthplace Galway, Ireland

16 (a) Informant Mr. E. D. Forgan
(b) Address 1829 Sutton Ave., Relay

17 (a) Burial (b) Date thereof 4/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Augustine's
Location Elkridge, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 10 1945 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7- 1945, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Due to
Other Conditions Multiple fractures, lacerations, abrasions, brush burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-7-45 at 12 ☐ 4 M.
(b) Where did injury occur? Sutton Ave. at St. Denis Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Waddell M.D.
Medical Examiner.
Date signed 4-8-45

G27709 ✓ G27709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2023 Herbert St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balti. Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 2, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace W. B. D. H. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Jacob miller
13. Birthplace Finkelstown, Md.
MOTHER 14. Maiden Name Doris Elkanor Noyes
15. Birthplace Balt. Md.
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 6 1945
18 (a) Funeral director Commissioner of Health
(b) Address
19 APR 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 3 10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1945 to 4/5 1945 and that I last saw h.i.m. alive on 4/5 1945

Immediate cause of death	Duration
Heart Failure	
Due to Dehydration	
Toxemia	
Due to Multiple Petechial Hemorrhages	
Other Conditions Possible Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Superficial Excoriations Skin
of autopsy Multiple p. Hemorrhages

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Doy M.D.
Address West Baltimore Gen. Hosp. Date signed 4/5/45 M. D.

VS 150

-632 X

G-631.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 631.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs 40 min.

2. USUAL RESIDENCE OF DECEASED: NONE.
(a) State W. Va. (b) County
(c) City or town Bluefield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1945

8. AGE: Years	Months	Days	If less than one day
			6 hr. 40 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Denver Martin KERby
13. Birthplace Clarksburg, Va.

MOTHER
14. Maiden Name Virginia Vaughn Nickels
15. Birthplace Bluefield, W. Va.

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 5 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945 19 , at 3½ A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 19 45 to April 4 1945, and that I last saw h.e.r. alive on April 4 19 45

Immediate cause of death	Duration
Asphyxia	
Due to Premature birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Russell Jr. M. D.
Address Hospital for Women of Md. Date signed 4-4-45

VS 150

631 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6771 1 6771 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 N Wash St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) **FULL NAME** Baby Boy Hennedy Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Boston Mass (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Sarah Hennedy
15. Birthplace

16 (a) Informant Joe Kennedy
(b) Address Hyannis Port Mass

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 10 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945.
and that I last saw h alive on 3-28 1945

Immediate cause of death Intracranial Hemorrhage — Duration
Due to Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cleveland Wood M.D.
Address University Hosp Date signed 4-7-45

VS 130

630

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G27712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Cutland Ave.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Cold Spring Lane #15
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Sollod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1945

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Norman Sollod
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marlene Katz
15. Birthplace Texas, Md.

16 (a) Informant Marlene Sollod
(b) Address 4024 Cold Spring Lane #15

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory JOHN HOPKINS MEDICAL SCHOOL APR 4 1945
Location

18 (a) Funeral director Commissioner of Health
(b) Address

APR 10 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945; at 5:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1945 to 3/31 1945, and that I last saw h[illegible] alive on 3/31 1945.

Immediate cause of death Atelectasis — Duration

Due to Prematurity (born 3 months premature) —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilfred K. Konigsberg M. D.
Address 1211 Eastern Ave. Date signed 4/1/45

-629 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 831

G27713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 N.Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or ~~No~~)
If yes, name country

3 (a) FULL NAME Cherie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Christian J.Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1895

8. AGE: Years	Months	Days	If less than one day
49	10	9	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Ackery
13. Birthplace Austria

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Christian Smith
(b) Address 513 N.Milton Ave.

17 (a) Burial (b) Date thereof April 12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John F. Miller
(b) Address 2034 Jefferson St.

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 10 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 4/9 1945, and that I last saw h alive on 4/7 1945

Immediate cause of death	Duration
Hemorrhage	
Due to Embolism	1 week
Due to Thrombosis of Blood Vessels	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 3901 Greenspring Ave Date signed 4/10/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Selena

G27714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108 Registered No. G27714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 651 W. Lee St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 651 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Selena Maser

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Lewis D. Maser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Lee
13. Birthplace Md

MOTHER
14. Maiden Name Ellen —
15. Birthplace Md

16 (a) Informant Lawood Maser
(b) Address 657 W. Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 11-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Sauer
(b) Address 1452 W. Hab St

19 (a) (b)
(Date rec'd by registrar) APR 10 1945 Huntington W Virginia, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 7 19 , at 350 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31- 1945, to 4-6- 1945, and that I last saw h[illegible] alive on Apr. 6 1945

Immediate cause of death	Duration
Bi Lateral Lobar Pneumonia	8 days.
Due to Cold.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Lawrence M. D.
Address 1033 W. Lanvale St Date signed 4/9/45

G27715 ✓ G27715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3543 Third St Balto. 25 Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 25 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3542 Third St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C VASCONCELLOS

3 (b) If veteran, name war [illegible]
3 (c) Social Security Account No. Federal Civil Service

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife Myrtle Vasconcellos
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1907

8. AGE: Years 38 | Months 2 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Taunton Mass
(Town, county, and state)

10. Usual Occupation Rigger Snapper

11. Industry or business U S Coast Guard
Curtis Bay

FATHER
12. Name Frank Vasconcellos
13. Birthplace Azore Island

MOTHER
14. Maiden Name Julia Pachoco Simas
15. Birthplace Azore Islands

16 (a) Informant Lionel M Vanwinkle
(b) Address 704 Pontiac Ave -(25)

17 (a) Burial (b) Date thereof April 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Nat'l Cemetery Arl. Va.
Location Virginia

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St Balto. 25 Md.

19 (a) APR 10 1945
(Date rec'd by Registrar)

Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1945, at 10.38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to April 7 1945, and that I last saw h~~im~~er alive on April 7 1945.

Immediate cause of death: congestive heart failure — Duration
Due to: rheumatic heart disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip W. Kiester MD
Address 302 Palapsco Ave Date signed 4/10/45

X

G27716 ✓ G27716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Yorkshire Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Coller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mollye

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

FATHER 12. Name Benjamin
13. Birthplace Russia

MOTHER 14. Maiden Name Clara
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

19 APR 10 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/45 19 . at 755 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 19 45 to 4/9/ 19 45, and that I last saw him alive on 4/9/ 19 45.

Immediate cause of death: Cerebral embolism
Pulmonary embolism
Thrombophlebitis, iliac
Due to Rheumat.-Arterial. Hr. dis.
Coronary sclerosis + insuff.
Due to: Myocardial insuff.

Other Conditions Pulmonary infarction
myocardial infarction, old.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley H. Steinberg
Address Sinai Hospital Date signed 4/9/45

G27717 G27717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied as correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto (If outside city limits, write RURAL and give town)

(d) Street No. 3802 Bonner Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Cazimsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph -

13. Birthplace Russia

MOTHER 14. Maiden Name -

15. Birthplace Russia

16 (a) Informant Jos. Cazimsky

(b) Address 3802 Bonner Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-45 (month) (day) (year)

(c) Cemetery or crematory Bradale

Location

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1719 E. Balto. St.

19 APR 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/1945, at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3/1945, to 4/9/1945, and that I last saw her alive on 4/9/1945

Immediate cause of death Cardio-Resp failure — Duration

Due to Myocardial Insuff. Cardio Degeneration

Due to Hypert: Arteriosl. Ht. Dis.

Other Conditions Emphysema - Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles H. Steinberg, M.D.

Address Sinai Hospital Date signed 4/9/45

Dr Jarrett. 11 E Chase St La 4747 G27718

G27718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 ae

Registered No. G27718

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 W Lexington St

(c) Hospital or institution: Aged Women & Aged Men Homes

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1400 W. Lexington St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Bettie Gathwright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Gathwright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24 1863

8. AGE: Years 81 | Months 5 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for Aged

FATHER

12. Name James Mookes

13. Birthplace Baltimore Co Md

MOTHER

14. Maiden Name Martha Duer

15. Birthplace Harford Co Md.

16 (a) Informant Records Aged Women's+Aged Men's Homes

(b) Address 1400 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)

(c) Cemetery Sherwood

Location Cockeysville Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 (Date received by registrar) APR 10 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1945, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/ 1927, to 4/7/ 1945, and that I last saw her alive on 4/6/ 1945.

Immediate cause of death Cerebral hemorrhage, rt. — Duration: about one yr.

Due to Arteriosclerosis generalized — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edwin B Jarrett M. D.

Address 11 E. Chase St., City Date signed 4/9/45

G27719 ✓ G27719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St
(c) Hospital or institution: University Hospital 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 1810
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bro. Y.M.C.A - Webster St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Margaret McFeeley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1903

8. AGE: Years	Months	Days	If less than one day
42	2	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Dispatcher

11. Industry or business B & O. R.R.

FATHER
12. Name Michael Kane
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McFah.
15. Birthplace —

16 (a) Informant Mr Michael Kane
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3501 Old Frederick Rd

18 (a) Funeral director Harry A Witzke
(b) Address 4101 E Lombard Ave

19 (a) APR 10 1945 (b) Registrar
Watchred by registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9- 1945, at 6.30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Miliary Tuberculosis of Lungs.
miliary

Due to 0

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 4-9-45

G27720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G27720 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 N. Lakewood
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Lakewood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geo. Schmidt

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-05-3147

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 23, 1881

8. AGE: Years 63 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Guard
11. Industry or business Bartlett & Hayward

FATHER
12. Name Eckhardt Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Marg. Bycker
15. Birthplace Balto. Md

16 (a) Informant Mrs. Emma Schmidt
(b) Address 619 N. Lakewood Av

17 (a) Burial (b) Date thereof Apl. 9, 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Windsor Mill Rd

18 (a) Funeral director L. Neumann & Son
(b) Address 32 S. Broadway

19 (a) APR 10 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Local Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apl 7. 1945, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1945 to April 7 1945, and that I last saw h— alive on April 6 1945.

Immediate cause of death Cerebral thrombosis —
2nd attack " "
Due to arterio - sclerosis.
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration
3/29/45 -
4/4/45 -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis F. Neumann M. D.
Address 722 N. Kenwood Av Date signed 4/9/45

X

G27721 MORAWSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G27721

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Morawski.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Marie Morawski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-86

8. AGE: Years 59 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Poland. (Town, county, and state)

10. Usual Occupation tailor

11. Industry or business

FATHER 12. Name Marion Morawski
13. Birthplace Poland.

MOTHER 14. Maiden Name ? Muszkowski
15. Birthplace Poland.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto City

18 (a) Funeral director Wm. J. Flatkowski
(b) Address 2007 Eastern Ave

19 (a) APR 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-1945, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7-1945 to 4-8 1945, and that I last saw h~~im~~ alive on 4-8-1945.

Immediate cause of death: Cardiac arrest
Due to: Infarction of myocardium
Due to: Arteriosclerotic heart disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dieke
Address Johns Hopkins Hospital Date signed 4/8/45

G27722
AB-32932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 B

G27722
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lee Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1914

8. AGE: Years	Months	Days	If less than one day
30	6 4	13	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Morgan (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Himphill (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof April 12, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Marion North Carolina
Location McDowell County.

18 (a) Funeral director Joseph A. Likely
(b) Address 419 N. Monroe St. Baltimore 3 Md.

19 (a) (b)
(Signature of local registrar)

APR 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1945, to 4-9- 1945, and that I last saw him alive on 4-9- 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to Pulmonary tuberculosis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Edward M. D.
Address Balto. City Hospitals Date signed 4-9-45
Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

940 Registered No. 627723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 E. Baltimore Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) February 1, 1903

8. AGE: Years	Months	Days	If less than one day
42	2	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John M. Wieczynski
13. Birthplace Szczuczyn, Germany

MOTHER
14. Maiden Name Anastasia Blaszkowska
15. Birthplace Poland

16 (a) Informant Mr. James Johnson
(b) Address 3122 E. Baltimore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) (Signature of Registrar) (b) Huntington Williams, M.D.

APR 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1945, to April 7 1945, and that I last saw her alive on 4/7 1945.

Immediate cause of death Myocardial insufficiency etc.
Due to Coronary heart disease
Due to Coronary occlusion of 7 yrs.
Other Conditions Gangrene of left leg
Multiple infarcts of lungs, liver, kidney
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See chart

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert Jenkins M.D.
Address Sinai Hosp. Date signed 4/7/45

G27724 G27724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 B

Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 h.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Concetta Raspi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1.24.27.

8. AGE: Years 18 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Luigi Raspi
13. Birthplace Italy

MOTHER
14. Maiden Name Pasqua Di Fulvio
15. Birthplace Italy

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) APR 10 1945 (b) Washington Williams M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1945, at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1945, to 4-9 1945, and that I last saw h[illegible] alive on 4-9 1945.

Immediate cause of death Cardiac failure
Pulmonary Edema

Duration 24 h.

Due to Tetralogy of Fallot —

Due to Pulmonary a-[illegible] 36 h.
a. Anastomosis -

Other Conditions Cerebral Hemorrhage, 30 h.
(Include pregnancy within 3 months of death)

Date of operation 4/7/45

Major findings of operation: Tetralogy of Fallot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr. M.D.
Address Johns Hopkins Hospital Date signed 4/9/45

VS 150

G27725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G27725

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Madison ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Madison ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Rather.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 - 1916

8. AGE: Years 29 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Brighty Rather.
13. Birthplace Va

MOTHER
14. Maiden Name Nanie Tours
15. Birthplace Va

16 (a) Informant Nanie Stewart
(b) Address 1208 Madison ave

17 (a) Removal (b) Date thereof 4-11-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Crewe Nottoway Co. Va.

18 (a) Funeral director Mrs Frances A. Reynolds
(b) Address 512 W. Biddle St.

19 (a) APR 10 1945 Hunting for Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 45 at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 29 1945 to April 8 1945 and that I last saw h alive on 19

Immediate cause of death: Lobar Pneumonia — Duration: 10 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H.C. Pettaway M. D.

Address 817 Hamilton Ave Date signed 4/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution: Pineridge Nursing Ho.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Berwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: NAOMI RINEHART

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frederick T. Rinehart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 11, 1879

8. AGE: Years 66 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Theodore Fornwalt
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Lydia Stermer
15. Birthplace: Pa.

16 (a) Informant: Miss Edna Rinehart
(b) Address: 2900 Berwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's Cem.
Location: Hampden, Md.

18 (a) Funeral director: WM. J. TICKNE & SONS
(b) Address: Balto., Md.

19 (a) APR 10 1945 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 8, 1945, at 11:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1942 to April 8 1945, and that I last saw her alive on April 7 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 wks
Due to: Arteriosclerosis	
Due to:	
Other Conditions: Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Dawson Mooney M. D.
Address 3105 Belair Rd Date signed 4-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27727 ~~G27727~~ G27727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G27727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA JULIA HAUS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William John Haus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1878

8. AGE: Years	Months	Days	If less than one day
66	3	20	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Henry Burman
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Letmate
15. Birthplace Balto., Md.

16 (a) Informant Mr. William John Haus
(b) Address 1806 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/45 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Violetville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 10 1945

MEDICAL CERTIFICATION P.

20. DATE OF DEATH April 7, 1945 at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1945 to Apr 7 1945, and that I last saw him alive on Apr 7 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	3 days
Due to Arteriosclerosis	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Burman Ford M. D.
Address 2200 Garrison Blvd Date signed 4/10/45

C27728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C27728 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1509 Park Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Wiza Price Jones

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Samuel Holliday Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	9	hr. min.

9. Birthplace Iowa
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Eugene B. Price
13. Birthplace Penna.

MOTHER
14. Maiden Name Ruth Weaver
15. Birthplace Penna.

16 (a) Informant: Mr. Samuel H. Jones
(b) Address 1509 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 9/9/45

VS 151

G27729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G27729 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Iris Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Iris Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michele Robusto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jennie Nardone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1895

8. AGE: Years 50 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Bricklayer

11. Industry or business Self

FATHER
12. Name Michele Robusto
13. Birthplace Italy

MOTHER
14. Maiden Name —
15. Birthplace Italy

16 (a) Informant Wife Jennie Robusto
(b) Address 1001 Iris Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Frank V. Pipitone
(b) Address 218 E. Baltimore Street

19 (a) Date received APR 10 1945 ...ington for William ...

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1945, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Febr 20 1943 to 4/7 45 and that I last saw h[illegible] alive on 4/7 45

Immediate cause of death — Duration

Pulmonary Tuberculosis — about 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Jankus M. D.

Address 1002 Mulberry Date signed 4/10/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

WC 1734871804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33B

Registered No. 27330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Smithson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernella Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-43

8. AGE: Years	Months	Days	If less than one day
1	4	6	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Vernon Simbley

13. Birthplace Md

MOTHER 14. Maiden Name Ruth Hall

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. B. Kelso

(b) Address 1303 Preastman St

19 (a) APR 10 1945 (Registrar) (b) Huntington Williams Md Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 9 1945 at 4 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 9 1945 and that I last saw h[er] alive on April 9 1945

Immediate cause of death H. influenzae

Due to Meningitis, type 3

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not reported

Duration
1
1 month

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.

Address JHH Date signed 4-7-45

X

G27731

J0492796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G27731

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wesley Hawkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John W. (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Scott (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month, day, year)
(c) Cemetery or crematory Gabriels
Location Md

18 (a) Funeral director Wes. G. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Date received APR 10 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1945, at 3:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 27, 1945, to Apr. 7, 1945, and that I last saw him alive on Apr. 7, 1945.

	Duration
Immediate cause of death Carcinoma of stomach with metastasis	7
Due to	
Due to	
Other Conditions Cardiac insufficiency due Bartonella bacilliformis infection (Include pregnancy within 3 months of death)	7

Date of operation
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 4-7-45 M. D.

G27732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27732

MARK "X" RESERVED FOR BRANDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4128 Mark Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4128 Mark Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth O. Blank

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1884

8. AGE: Years	Months	Days	If less than one day
60	3	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph A. Gibson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Blakley
15. Birthplace Baltimore, Md.

16 (a) Informant Louise E. Blank
(b) Address 4128 Mark Ave

17 (a) Burial (b) Date thereof 4/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 4914 Belair Road

19 (a) APR 10 1945 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945 at 1 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1939, to April 8 1945, and that I last saw h[illegible] alive on April 8 1945.

Immediate cause of death
a. Myocarditis
Pulmonary Edema
Due to Chr Myocarditis
arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1. 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Hardesty M.D.
Address 4840 Belair Rd Date signed April 9 1945

G27733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G27733
Registered No.

1. PLACE OF DEATH: found in Harbor,
(a) Baltimore City, Maryland
(b) Street address Pier 4 Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. Jasper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alphonso Haughton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Myrtle Haughton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1917

8. AGE: Years 28 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Reedsville, N. C.
(Town, county, and State)

10. Usual Occupation Feller

11. Industry or business

FATHER
12. Name Henry Haughton
13. Birthplace Reidsville N. C.

MOTHER
14. Maiden Name Gertrude Reese
15. Birthplace N. C.

16 (a) Informant Mrs. Ruth Brooks (Sister)
(b) Address 593 Baker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945, at 11:55 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Found Drowned.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/1/45 at ? M.
(b) Where did injury occur? Harbor, Pier 4 Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found Drowned.

23. Signature Howard J. Messerie M.D.
Medical Examiner.
Date signed April 10, 1945.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 151

G27734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B Registered No. G27734

CWK-92821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 ds
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Redmond or Redwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1876

8. AGE: Years	Months	Days	If less than one day
68	10	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Smith (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Goings (D)
15. Birthplace Maryland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Edwin H. Alexander
(b) Address 927 N. Mount St.

APR 10 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-45 19 , at 3:30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945, to April 8 1945, and that I last saw her alive on April 8 1945

Immediate cause of death Carcinoma Stomach — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3/30/45

Major findings of operations Bowel obstructed due to Ca metastases

Findings of autopsy: Ca of Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Perry M.D.
M. D.
Address BCH Date signed 4-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G27735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 W. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 W. Lafayette Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Weaver Emerson Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-2193

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1902

8. AGE: Years 43 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation U. S. Government

11. Industry or business

FATHER 12. Name Emmanuel C. Watkins

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Maria F. Bowers

15. Birthplace San Francisco, Calif.

16 (a) Informant Mrs. Maria F. Watkins

(b) Address 711 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-45 (month) (day) (year)

(c) Cemetery or crematory Nat. Auburn

Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Ave.

19 APR 10 1945 (Date Rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to April 9 1945, and that I last saw him alive on April 1 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days
Due to	
Due to Not determined	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 84 Stark Rd Date signed 4-9-45

VS 3

627736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 627736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE IN SPACES RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Erdman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sandra Lee Barnhart

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Child

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 19, 1938

8. AGE: Years	Months	Days	If less than one day
6	3	20	hr. min.

9. Birthplace Uniontown, Pa. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Jacob Barnhart, Jr.
13. Birthplace Fayette Co., Pa.

MOTHER
14. Maiden Name Celta Kegg
15. Birthplace Fayette Co., Pa.

16 (a) Informant Jacob Barnhart, Jr. (Father)
(b) Address 5000 Erdman Ave. (5)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Sylvian Hgts. Cem.
Location Fayette Co., Pa.

18 (a) Funeral director R. Howard Evans
(b) Address 1646 S. Chapel St.

19 (a) APR 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1945, at 3:05 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/4
(a) Date of injury 4-9-45 at 2:30 P.M.
(b) Where did injury occur? Wright Ave & Creighton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Struck by BTC bus.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 10, 1945

G27737 BALTIMORE CITY HEALTH DEPARTMENT G27737
CERTIFICATE OF DEATH 131a Registered No.

RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139 North Curley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Curley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susanna Barbernitz

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Michael(dead)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1870

8. AGE: Years 74 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation housewife at home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Hungary

MOTHER
14. Maiden Name Anna Jacob
15. Birthplace Hungary

16 (a) Informant Peter M. Barbernitz
(b) Address 7915 Elmhurst Ave #6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street.

19 (a) 1945 Huntington Williams, M.D. Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Sunday~~ Wed Sunday 8th 1945 at 10:10 A.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 45 Sept 8 1945 and that I last saw alive on Sept 8 1945

Immediate cause of death: Senility — Duration
Due to: Arteriosclerosis
Due to: Chronic Gastritis & Hypostatic
Due to: Acute Heart Decomp.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature J. Kent Curley M. D.
Address 2536 E Balt Date signed 4/9/45

X

G27738 G27738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1714 E. Monument

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 433 N. Kenwood (If rural give location)

(e) Citizen of foreign country? ? (Yes or No) If yes, name country

3 (a) FULL NAME John George Tuerk

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0265

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret A. (nee Richter)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 28, 1873

8. AGE: Years 71 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sabastian Tuerk

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Adam G. Tuerk - son

(b) Address 433 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)

(c) Cemetery or Oak Lawn

Location Eastern Avenue Road

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601-03 E. Madison St.

19 (a) 10 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2:30 p.m. April 9th M.

(b) Where did injury occur? Above address

(c) Did injury occur at home, on farm, industrial place, in public place? None While at work? no

(d) Means of injury Turned on Gas jet

23. Signature John K. Davis M.D. Medical Examiner

Date signed 4/9/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G27739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1273 Riverside Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1273 Riverside Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Annie Thuman Nagell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Nagell
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	7	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Joseph H. Thuman
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Senger
15. Birthplace Germany

16 (a) Informant Frank J. Nagell
(b) Address 1271 Riverside Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Co., Md.

18 (a) Funeral director H. A. Mears and Son
(b) Address Baltimore, Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

APR 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 10 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1945, to 4/9 1945, and that I last saw her alive on 4/9 1945.

Immediate cause of death (a) Chronic Endocarditis — Duration 6 mo.
Due to Arteriosclerosis — 1 yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. B. Whelits MD
Address 1279 Williams Date signed 4/10/45 M. D.

G27740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 940

G27740
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 Ramsay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Ramsay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ellen Knell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Charles B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1889

8. AGE: Years	Months	Days	If less than one day
56	1	5	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Isaac Hawes
13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah Ashby
15. Birthplace Virginia

16 (a) Informant Charles B. Knell
(b) Address 1516 Ramsay St.

17 (a) Burial (b) Date thereof 4/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Henry A. Wetzke
(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date received by registrar) Registrar

APR 10 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION 20

20. DATE OF DEATH April 9 1945, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1945, to April 9 1945; and that I last saw h[illegible] alive on April 9 1945.

Immediate cause of death Coronary Thrombosis

Due to Coronary Sclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
—

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury

23. Signature H. B. Thomas M. D.
Address 716 Cathedral St. Date signed 4-10-45

VS 150

X

G27741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G27741

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: Hospital, Ward 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Carlton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1873

8. AGE: Years 71 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Cambridge
(Town, county, and state)

10. Usual Occupation Old age pension

11. Industry or business

FATHER
12. Name
13. Birthplace Md.

MOTHER
14. Maiden Name Jane ?
15. Birthplace Md.

16 (a) Informant Either pt. or Eleanor Hughes, daughter
(b) Address 1637 E. Madison St.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Baltimore Maryland

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

APR 10 1945
(Date rec'd by registrar)

(a) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1945, at 5:07 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945, to 4/7 1945, and that I last saw h~~im~~ alive on 4/7 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchogenic Carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/23/45

Major findings of operation: Primary tumor on left chest carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D. Chaput M. D.

Address University Hospital Date signed 4/7/45

X

G27742 CWK-91582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G27742 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item, of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 2- 25
(e) Length of stay in Baltimore (yrs., mos., or days) 69- 3- 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Mae Swingler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Louis W. Swingler

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec. 31-1876

8. AGE: Years 68 | Months 3 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retd Nurse

11. Industry or business Self

FATHER
12. Name Charles Frayer
13. Birthplace Germany

MOTHER
14. Maiden Name Phoebe Ruff
15. Birthplace ? Md

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Easter Avenue

17 (a) Burial (b) Date thereof 4/11/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto Md
Location

18 (a) Funeral director William Cook Inc
(b) 4PR 10 1945 St Paul at Huntington Ave, Md

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 8:12 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to April 8 1945, and that I last saw her alive on April 8 1945

Immediate cause of death SHOCK — Duration ...

Due to OPERATION — Duration 24-36 hrs.

Due to FAT EMBOLISM? — Duration ...

Other Conditions FRACTURED FEMUR — Duration 3 mos.

(Include pregnancy within 3 months of death)

Date of operation 4-7-45

Major findings of operation: fractured Neck femur, right

of autopsy: arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following for Medical Study

(a) Accident, suicide or homicide?

(b) Date of occurrence 1-13-45 5:1 M

(c) Where did injury occur? Home Balto Md.
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)

(e) Means of injury fell down steps

Signature R. M. Cunningham M. D.

Address Balto City Hosp. Date signed 4-9-45

To be approved by Medical Examiner

For A. R. Davis, By Howard J. Mueller M.D.

G27743

G27743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: ST Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12da.
(e) Length of stay in Baltimore (yrs., mos., or days) 63yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Federal Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME James J Anderson.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Erma Schroeder

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	30	..... hr. ..... min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation Plumber.

11. Industry or business .....

FATHER
12. Name Daniel J. Anderson.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Bridget ?
15. Birthplace Ireland.

16 (a) Informant Mrs. Erma Anderson
(b) Address 1104 E. Federal St

17 (a) Burial (b) Date thereof 4/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Ave

18 (a) Funeral director George J. Ruth Inc
(b) Address 1735 Hoffman Ave.

19 (a) ..... (b) Huntington Williams
(Date received by registrar) APR 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10-45 1945 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1945 to 4-10 1945; and that I last saw him alive on 4-10 1945

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Hypertensive Cardio-vascular disease Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Eugene J. Riley M. D.
Address St Joseph's Hospital Date signed 4-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amanda E. Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Thomas R. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1859

8. AGE: Years	Months	Days	If less than one day
85	8	15	hr. min.

9. Birthplace Prince George County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

MOTHER / FATHER
12. Name Leonard Harvey
13. Birthplace Maryland
14. Maiden Name Charity Ann Jones
15. Birthplace Maryland

16 (a) Informant Mrs. Mabel Myers
(b) Address 229 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Ellis Funeral
(b) Address 4510 Liberty Heights Ave.

19 (a) Date received by Huntington Williams, M.D. Registrar

APR 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 7.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11- 1945 to Apr. 8- 1945, and that I last saw her alive on Apr. 8 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Advanced Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Lavois M. D.
Address 1700 Eutaw Place Date signed Apr. 9-1945

X

G27745 471764

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G27745

CERTIFICATE OF DEATH 1315

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Finksburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilmer Ward.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: White.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-31-97 1887

8. AGE: Years 58. Months 2 Days 10 If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Farmer.

11. Industry or business

FATHER 12. Name Joseph Ward.

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Annie Poole

MOTHER 15. Birthplace Md

16 (a) Informant Friend.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Sandy Mount

Location Carroll Co. Md

18 (a) Funeral director C. M. Wells

(b) Address Winfield Md

19 APR 11 1945 (Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 10 - 1945 at 10. P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 10 1945 and that I last saw him alive on April 10 1945.

Immediate cause of death: Respiratory failure

Due to: Uremia

Due to: Hypertensive Cardiovascular Disease

Due to: Chronic nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Dieas

Address Johns Hopkins Hospital 4/10/45

G27746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 E. 28th St
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Foos

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Mary T. Foos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16th 1869

8. AGE: Years 75 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Oven Builder

FATHER
12. Name James N. Foos
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Cunningham
15. Birthplace Balto. Md.

16 (a) Informant Lula Poehlman
(b) Address 2543 Park Ave

17 (a) Burial (b) Date thereof 4/12/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

APR 11 1945 Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to April 9 1945 and that I last saw him alive on April 6 1945.

Immediate cause of death	Duration
Chronic Coronary Sclerosis	3 years
Due to Arteriosclerosis	5 years
Other conditions Amputation right leg above knee	

(Include pregnancy within 3 months of death)

Date of operation March 14 1945

Major findings of operation Endarteritis

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? Home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 5706 Fairfield Rd Date signed 4/10/45

VS 150

G27747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G27747 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Sidman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 126-03-3916

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Sep, W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/1887

8. AGE: Years 57 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Cook-Chef

11. Industry or business Miller Bros

FATHER
12. Name Alonzo Sidman
13. Birthplace New York

MOTHER
14. Maiden Name Mary E. Miller
15. Birthplace New York.

16 (a) Informant Harry W. Sidman
(b) Address 55 Eastern Pky N.Y.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

19 (a) (Date received by Registrar) APR 11 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945 to 4/8 1945 and that I last saw him alive on 4/8 1945

Immediate cause of death Uremia

Due to Hypertensive C-V. Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. K. Spedden M. D.

Address Mercy Hosp. Date signed 4/8/45

X

627748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. 627748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp. Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto #27 Municipal
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 Circle Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norbert A. Wilkinson

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mrs. Gonia Wilkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8th 1896

8. AGE: Years	Months	Days	If less than one day
49	1	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Sanitary Inspector
11. Industry or business Balto City Health Dept.

FATHER
12. Name Alexander Wilkinson
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary White
15. Birthplace Unknown

16 (a) Informant Norbert A Wilkinson
(b) Address 1253 Circle Drive Balto #27

17 (a) Entombment (b) Date thereof 4/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount Mausoleum
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 Date received APR 11 1945 (By) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1945, at 12:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 4/9 1945 and that I last saw h. alive on 4/9 1945

Immediate cause of death Uremia — Duration

Due to Congen Polycystic Kidneys

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Mosberg Jr.
Address Univ. Hosp. Date signed 4/9/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

627749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellwood Shider

3 (b) If veteran, name war	3 (c) Social Security Account No.
M	NRA

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13th 1901

8. AGE: Years	Months	Days	If less than one day
43	6	27	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Radio Technician
11. Industry or business Self

FATHER
12. Name George H. Shider
13. Birthplace York Pa.

MOTHER
14. Maiden Name Hattie R. Becker
15. Birthplace Balto. Md.

16 (a) Informant Louise Becker
(b) Address 4607 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Green Mount
Location York Pa

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 APR 11 1945 (Date rec'd by reg. dept.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945 at 12 30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-10-45

VS 151

G27750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G27750

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 386 Edgewater Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Clements

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1945

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Edith Clements
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

APR 11 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1945, to March 30 1945 and that I last saw him alive on March 30 1945.

Immediate cause of death	prematurity	Duration
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. I. Griffith M. D.
Address Johns Hopkins Hospital Date signed 4-2-45 M. D.

2041 X

G27751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G27751

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) ~~City~~ or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Duncan Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dianne Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1945

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name David Thompson
13. Birthplace South Carolina

MOTHER

14. Maiden Name Harriet Barnes
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 11 1945 (Date rec'd by registrar) Hunter Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945, to March 30 1945, and that I last saw her alive on March 30 1945

Immediate cause of death intracranial hemorrhage and cardiac decompensation — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. I. Griffith M. D.
M. I. Griffith M. D.
Address Johns Hopkins Hospital Date signed 4-2-45

343 X

77752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 6-27752

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N Arlington Ave (or rural route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Norman NORMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/45

8. AGE: Years | Months | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Norman
13. Birthplace

MOTHER 14. Maiden Name Maryland Norman
15. Birthplace

16 (a) Informant Hosp Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 11 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 7 1945 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1945, to Apr 7 1945 and that I last saw h[illegible] alive on 4-7 1945

Immediate cause of death	Duration
Loss pneum	20 Days
Due to	
Due to	
Other Conditions Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 4-9

1642

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27753 ✓ G27753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts

(c) Hospital or institution Franklin Square Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1323 W Lombard ST (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Andrew Matthews

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 213-09-913[illegible]

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1892

8. AGE: Years 57 Months 4 Days 29 If less than one day hr. min.

9. Birthplace Leith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Andrew Matthews

13. Birthplace Leith

MOTHER 14. Maiden Name

15. Birthplace Leith

16 (a) Informant ANNA JAKUBAUCKAS

(b) Address 35 Lineyck St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 12 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director Joseph Kasmakas Jr

(b) Address 602 Washington Blvd

19 (a) (b) Huntington Williams Registrar

APR 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1945, at 3 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1945 to 4-9 1945; and that I last saw h[illegible] alive on 4-9 1945.

Immediate cause of death Shock — Duration 1 day

Due to intestinal obstruction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. H. Kerpmann M.D. M. D.

Franklin Sq. Hosp Date signed 4-10-45

X

G27754

BALTIMORE CITY HEALTH DEPARTMENT

TN. 92939 **CERTIFICATE OF DEATH** 93D

Registered No. G27754

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Flora St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Premis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
80 ?	?	?	hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Apr 12 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Eutaw Place Balto

19 APR 11 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th, 1945 19 at 4.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4-45 19 to 4-6-45 19, and that I last saw him alive on April 6th 19 45

Immediate cause of death	Duration
Coronary occlusion	?
Due to Arteriosclerosis	?
Heart disease & Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 4-10-45

G27755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27755

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 N Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. D. Danekes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or ~~wife~~ Agnes J. Danekes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1865

8. AGE: Years 79 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David H. Danekes
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth E. Meekins
15. Birthplace Virginia

16 (a) Informant Agnes J Danekes
(b) Address 34 N Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John E Moran
(b) Address 2900 E Baltimore St

19 (a) APR 11 1945 (Date rec'd by registrar) (b) Registrar

Huntington Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apl 1, 45 to Apl 8 1945.
and that I last saw h~~i~~m alive on Apl 8 45.

Immediate cause of death Sarcoma Secondary
Due to Cardiac Heart Disease
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Insley M. D.
Address 2936 E Balt Date signed 4-9-45

G27756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G27756 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Baylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1875

8. AGE: Years 70 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace King William Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Colyman Baylor

13. Birthplace King Wm Co. Va.

MOTHER 14. Maiden Name " "

15. Birthplace Unknown

16 (a) Informant Llewellyn Johnson

(b) Address 3 37 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1945 (month) (day) (year)

(c) Cemetery or crematory Family Section

Location King William Co. Va

18 (a) Funeral director Hugh Lee H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) APR 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1945 to 4/9 1945, and that I last saw h[illegible] alive on 4/9 1945.

Immediate cause of death: Hypertensive Cardiovascular Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Bouyer, M.D.

Address Provident Hospital Date signed 4/10/45

VS 150

627757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 627757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boisey Nicholson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1910

8. AGE: Years	Months	Days	If less than one day
34	11	27	hr. min.

9. Birthplace Rockingham, N.C.
(town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name
13. Birthplace Rockingham, N.C.

MOTHER
14. Maiden Name Nicholson
15. Birthplace N.C.

16 (a) Informant Mary Nicholson
(b) Address 1801 Division St

17 (a) Burial (b) Date thereof 4.11.45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Natl. Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Wallace
(b) Address 1631 Druid Hill Ave.

19 APR 11 1945 Hunter Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage -
Due to
Other Conditions Fractured jaw - multiple lacerations.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-5- at 478 ? M.
(b) Where did injury occur? ?
(c) Did injury occur at home, on farm, industrial place, in public place? ? While at work? ?
Means of injury ?

23. Signature Horace S. Warren M.D.
Medical Examiner.
Date signed 4-9-45

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G27758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Hite (Hight)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-15-13
8. AGE: Years 32 Months 2 Days 24 If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name Johnny Hite
13. Birthplace Va
MOTHER 14. Maiden Name Mary Hite
15. Birthplace Va.
16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 19 45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md
18 (a) Funeral director Mrs. Lucy A. Hull
(b) Address 1621 Druid Hill Ave.
APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 9 a.m. M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1945 to Apr 9 1945 and that I last saw her alive on Apr 9 1945
Immediate cause of death Uremia
Aspiration pneumonia
Due to Hypertensive Cardio-Vascular disease
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirm clinical

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abraham Simon M. D.
Address Johns Hopkins Date signed 4-13-45

VS 150

527759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. 527759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2512 Talbot Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Talbot Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise D. Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1877

8. AGE: Years 67 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation General Supervisor

11. Industry or business of Terminals B. & O. R.R.

FATHER
12. Name Thomas Ward
13. Birthplace N. Y.

MOTHER
14. Maiden Name Mary Marren
15. Birthplace Ohio

16 (a) Informant Mrs. Louise D. Ward
(b) Address 2512 Talbot Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

APR 11 1945 (Date received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 5.00

20. DATE OF DEATH April 10, 1945 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1943 to April 10 1945. and that I last saw him alive on April 5 1945

Immediate cause of death: Suppuration & Ischiorectal abscess

Due to: Secondary malignancy spine & pelvis — Duration: weeks

Due to: Carcinoma Prostate Gland 2. (?)

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Jan. 1945

Major findings of operation: Castration.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 925 N Charles St Date 10 Apr 45

VS 150

27760 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 27760

CERTIFICATE OF DEATH

931D

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 W. Belvedere Ave St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ...yrs. ...mos. How long in U. S. If of foreign birth? ...yrs. ...mos. ...da.

2. FULL NAME Gustav W. Giesler

If U. S. Veteran specify WAR .....

(a) Residence: No. 3706 W. Belvedere Ave St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Jones Giesler

6. DATE OF BIRTH (month, day, year) Oct. 6, 1868

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
76	6	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Construction Supt.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

FATHER

13. NAME Geo. W. Giesler

14. BIRTHPLACE (city or town) Bavaria
(State or country)

MOTHER

15. MAIDEN NAME Dorothy Ackler

16. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

17. INFORMANT Emma Lembert
(Address) 3706 W. Belvedere Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place London Park Date 4-11 19 45

19. UNDERTAKER Loring Byers
(Address) 3605 Park Heights Ave.

20. FILED APR 11 1945 Huntington Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4-8, 1945

22. I HEREBY CERTIFY, That I attended deceased from July 25th, 1944, to April 8th, 1945

I last saw h... alive on April 8th, 1945. Death is said to have occurred on the date stated above, at 11:35 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	1944
Coronary Sclerosis	1944
Art. Sclerosis	5 years
Other contributory causes of importance: Cerebral Hemorrhage	5 days

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation ..... What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19...

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) James L. Duffy M.D.

(Address) Pikesville, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 8

G27761 ✓ G27761

CWK-92814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Ds.
(e) Length of stay in Baltimore (yrs., mos., or days) 72- 2- 12 Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neven Sheets (Neven Jacob Sheets)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-16-5054

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Isabelle Sheets
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31-1873

8. AGE: Years	Months	Days	If less than one day
72	2	8	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation Painter - retired
11. Industry or business

FATHER
12. Name Jacob Sheets
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Dutrow
15. Birthplace Maryland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945, to April 9 1945, and that I last saw h.. im alive on April 9 1945.

Immediate cause of death Uremia — Duration Last

Due to Cardiac Failure — 7 Days

Due to Neurogenic Bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac Failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E J Berry M.D.
Address BCH Date signed 4-4-45

G27762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27762

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 N. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADOLPH C. BRANDT

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife Catherine Brandt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1865

8. AGE: Years	Months	Days	If less than one day
80	2	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Furniture Dept.
11. Industry or business Stewart & Co.

FATHER
12. Name ? Brandt
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mr. Preston Pairo
(b) Address

17 (a) Burial (b) Date thereof 4/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 11 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945 at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1945 to 4/10 1945, and that I last saw h[illegible] alive on 4/10 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 4 hours
Due to: Cardio Vascular Disease — 4 year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elist W Johnson
Address 3432 Fredrick Ave Date signed 4/11/45 M. D.

VS 150

G27763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G27763 Registered No.

RESERVED FOR BINDING

MARG

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Belmont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3025 Belmont Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E. DeCORSE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank DeCorse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1877

8. AGE: Years 68 | Months 0 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas W. Pumphrey
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Cooper
15. Birthplace Md.

16 (a) Informant Mr. Frank DeCorse
(b) Address 3025 Belmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Maryland

APR 11 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1942, to Apr. 9, 1945, and that I last saw her alive on Apr. 9, 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eagle A. Kemp M.D.
M. D.
Address 3030 Edmondson Ave. Date signed 4/10/45

X

G-27764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 C

Registered No. G-27764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4705 Norwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Lee Elliott

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife: Julia M. Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-07

8. AGE: Years 38 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Eastport Maryland
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Benjamin H. Elliott
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel E. Stevens
15. Birthplace Maryland

16 (a) Informant Self
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)

(c) Cemetery or crematory
Location Big Stone Gap, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. REGISTRAR

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10- 1945 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1945 to 4-10 1945 and that I last saw h.i.w. alive on 4-10 1945

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Toxemia	
Due to Pregnancy	
Other Conditions Cancer of duodenum	

(Include pregnancy within 3 months of death)
Date of operation 4-9-45
Major findings of operation: Cancer of duodenum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. O. Moon, M.D.
M. D.
Address 4 MMH. Date signed 4-10-45

X

G27765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G27765 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 E. Lombard
(c) Hospital or institution:

3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 E. Lombard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Artis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	✓

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Petersburg Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business Home Maker

FATHER 12. Name Claiborne Reed
13. Birthplace Petersburg, Va

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Arlene Artis Stephens
(b) Address 1531 E. Lombard

17 (a) Burial (b) Date thereof 4-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

APR 11 1945 (Huntington Williams) Md.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1945 to Apr 8 1945 and that I last saw h alive on Apr 6 1945

Immediate cause of death	Duration
Carcinoma of the mammary gland	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.
Address 2 E. Monument Date signed 4/9/45

627766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 627766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 876 Lyon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Watson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black.	Married

6 (b) Name of husband or wife Jane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 14 - 98

8. AGE: Years	Months	Days	If less than one day
46.	11	25	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bleay Watson
13. Birthplace S.C.

MOTHER
14. Maiden Name Sarah Waterman
15. Birthplace S.C.

16 (a) Informant Reynolds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)

(c) Cemetery or crematory
Location Winnsboro, S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 (a) APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 9 1945, at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1945, to April 9 1945, and that I last saw him alive on April 9 1945.

Immediate cause of death	Duration
Pneumonia	
Due to Pneumococcus.	
Due to	
Other Conditions Bilirubinemia.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Denlinger M. D.
Address Johns Hopkins Date signed 4-9-45

VS 150

G-77767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G-77767

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 E. Baltimore (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Esther Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Joseph.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Hilda
15. Birthplace Russia

16 (a) Informant Mrs. Ida Block
(b) Address 3300 Dupont Ave -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-45 (month) (day) (year)
(c) Cemetery or crematory Ahavath Chasim
Location Wash. Rd

18 (a) Funeral director Jack Lemkin
(b) Address 1709 E. Balto St.

APR 11 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1945, at 9:40 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio - vascular renal disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Hugh B McCaddy M.D. Medical Examiner.
Date signed 4/11/45

VS 151

627768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627768 1860 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 E. 29th St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Vernon B. Wheat

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-2223

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Julia E. Wheat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1885

8. AGE: Years	Months	Days	If less than one day
59	5	12	..... hr. ..... min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Sears, Roebuck & Co.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Lizza Rye
15. Birthplace Unknown

16 (a) Informant Mrs. V. B. Wheat
(b) Address 1808 E. 29th Street, Balto.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto., Md.

18 (a) Funeral director Lovedale Funeral Home
(b) Address 7401 Belair Road

19 (a) ADD 4-11-1945 (Date received by Registrar) (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10/45 19..... at 1:32 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/10/45 12:30 P.M.
(b) Where did injury occur? at home - E. 29th St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Fell down stairs

23. Signature P. J. Lubinski M.D. (Medical Examiner)
Date signed 4/10/45

G27769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G27769 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Eleventh Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Guilford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary McKenna
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 7, 1872

8. AGE: Years	Months	Days	If less than one day
73	-	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Thomas McKenna
13. Birthplace Ireland

MOTHER 14. Maiden Name Anna McCaughan
15. Birthplace Ireland

16 (a) Informant Jos. V. McKenna
(b) Address 327 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director H. C. Brauning & Son
(b) Address 2924 Edmondson Ave

19 (a) APR 11 1945 (b) Registrar by Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1945, at 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1945, to April 10 1945, and that I last saw h[illegible] alive on April 10 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to generalized metastasis from	2m
Due to Lymphosarcoma of tonsil	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: generalized met. to liver & [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Roy B. Turner M. D.
Address Mercy Hospital Date signed 4/10/45

62770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

62770 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-0342

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant William Alexander
(b) Address 1127 E. Orleans st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn A. R. Co.

18 (a) Funeral director Fred Bailey
(b) Address 1421 E. Jefferson st

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport, Md.

APR 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic Aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D. Medical Examiner.
Date signed 4-10-45

G27771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B 30 E

Registered No. G27771

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie May Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1910

8. AGE: Years 35 | Months 6 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Shaw
13. Birthplace N. C.

MOTHER
14. Maiden Name Cora Foote
15. Birthplace N. C.

16 (a) Informant Graham Solomon
(b) Address 723 Harford Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 11 45 (month) (day) (year)

(c) Cemetery or crematory
Location Littleton N. Carolina

18 (a) Funeral director Mrs Robert O. Ellwood
(b) Address 1129 N. Caroline St

APR 11 1945 (Date rec'd by registrar)

(b) Huntingtown, Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to April 7 1945, and that I last saw her alive on April 7 1945

Immediate cause of death	Duration
Pulmonary Hemorrhage.	
Due to Chr. Pulmonary Tuberculosis	
Due to Luetic Heart Disease	
Other Conditions Marasmus, Myelofibrosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary G. Dunn M. D.
Address 118 Diagnal Date signed 4/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G27772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1065 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phyllis Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (d) Single, married, widowed, or divorced: Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1945

8. AGE: Years | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joshua Anderson
13. Birthplace Pembrook, N.C.

MOTHER
14. Maiden Name Rosalie Dixon
15. Birthplace Lumberton, N.C.

16 (a) Informant Mrs. Rosalie Dixon
(b) Address 1065 W. Lexington St.

17 (a) Mt. Auburn (b) Date thereof 4-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans + Md.

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 1331 Schroeder St
APR 11 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage, Traumatic

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 8, 1945 R/2 M.
(b) Where did injury occur? 1065 W. Lexington
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Mother fell down stairs with child

23. Signature Louis A. Frieden M.D.
Medical Examiner.
Date signed 4-10-45

G27773 TH.3

92798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G27773

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 919 N. Arlington Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27-1867

8. AGE: Years 78 | Months 0 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Dennis Young

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden Name Celie Hall

MOTHER — 15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-'45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Willia

(b) Address 322 N. Schroeder St

19 (a) APR 11 1945 Date rec'd by Registrar (b) Registrar Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1945, at 8.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 1945 to April 7 1945 and that I last saw h[illegible] alive on April 7th, 1945

Immediate cause of death: Myocardial insufficiency — Duration ?

Due to: Arteriosclerotic heart disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature J. M. Pugsley M.D.

Address Balt City Hosp Date signed 4-9-45

G27774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27774

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Fremont
(c) Hospital or institution: Lowndes & Green University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 119 N. Fremont (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERTA SUTTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife J. James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2 1892

8. AGE: Years	Months	Days	If less than one day
52	8	6	hr. min.

9. Birthplace A. A. County, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Kager
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Katie Baker
15. Birthplace A. A. County, Md.

16 (a) Informant Edward Coden
(b) Address 119 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 332 N. Schroeder St.

19 (a) APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/45 19..... at 10:35 AM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D.
Medical Examiner.
Date signed 4/8/45

G27775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G27775 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Edward Bulls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1900.

8. AGE: Years	Months	Days	If less than one day
44	6	18	hr. min.

9. Birthplace Darlington, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jordon Bulls
13. Birthplace Darlington, S.C.

MOTHER
14. Maiden Name Virginia Dial.
15. Birthplace Darlington, S.C.

16 (a) Informant Mrs. Hattie Bulls.
(b) Address 1002 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie B. Willis
(b) Address 322 N. Schroeder St.

19 APR 11 1945 (Date received by Registrar) (b) Huntington Wil. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 4:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to 3rd degree burns 7 legs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 23/3
(a) Date of injury Feb 2, 1945 M.
(b) Where did injury occur? Spring Gardens Plant Sun Co. Chem.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Clothing ignited

23. Signature Robert Von Hatzfeld M.D.
Medical Examiner.
Date signed April 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

627776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 627776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1042 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Argyle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Anthony

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Gilbert L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1899

8. AGE: Years 45 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Washington Gordon
13. Birthplace Orange Co. Va.

MOTHER
14. Maiden Name Texanna Randolph
15. Birthplace Charlottesville, Va.

16 (a) Informant Ruth Johnson(Sister).
(b) Address 1042 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

Date received APR 11 1945 by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1945, at 9:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 4/9 1945, and that I last saw [illegible] alive on 4/9 1945.

Immediate cause of death: cerebral hemorrhage — Duration: 9 hrs

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Cooper M.D.
Address 512 Cath Date signed 4/10/45

G27777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G27777

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Bel Air Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Bel Air Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MATTHEW JAMES WALSH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ellen Hennessy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1862

8. AGE: Years	Months	Days	If less than one day
83	1	14	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Thos Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Farmer
15. Birthplace Ireland

16 (a) Informant Mrs Hayden
(b) Address 3605 Bel Air Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory St Charles
Location Catonsville, Baltimore Co

18 (a) Funeral director J. J. Gahegan & Son
(b) Address 18 Light St.

19 APR 11 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945 at 9.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 9, 1945 to April 9, 1945 and that I last saw h.[illegible] alive on April 9, 1945.

Immediate cause of death Carcinoma left arm — Duration

Due to

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Davis,
Address 211 Medical Arts Date signed 4/9/45

G27778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27778

85

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St Joseph's Hospital. 81
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 E. Lafayette
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country.....

3 (a) FULL NAME WILBUR LOUIS HAMILTON, JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	220-05-8458

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1913

8. AGE: Years	Months	Days	If less than one day
31	6	29	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation - Clerk.
11. Industry or business Retail Merchants

FATHER
12. Name Wilbur L. Hamilton, Sr.
13. Birthplace Hereford, Maryland

MOTHER
14. Maiden Name Mathilda Scheuerman
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mathilda E. Hamilton
(b) Address 2314 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 6.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1945 to 4-9 1945 and that I last saw him alive on 4-9 1945.

Immediate cause of death	Duration
(a) Cardio-respiratory failure	
Due to (b) Physical exhaustion	
Due to (c) Status Epilepticus and Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? Cemetery (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....

23. Signature Eugene J. Riley M. D.
Address St Joseph's Hospital Date signed 4-9-45

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

G27779 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Green

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1944

8. AGE: Years	Months	Days	If less than one day
	6	7	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Edward Green
13. Birthplace Md

MOTHER
14. Maiden Name Frances Carter
15. Birthplace Md.

16 (a) Informant 921 N. Carrollton Ave
(b) Address Frances Green

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/45 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

19 APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at 1:45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus — lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed April 10 1945

G27780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27780

G27730 G-6729 13 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Mackel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1895

8. AGE: Years 50 | Months 0 1 | Days 5 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathaniel Mackel (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Wade (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory Evergreens
Location Md.

18 (a) Funeral director Ged. H. Kelson
(b) Address 1303 Pressman St.

19 (a) APR 11 1945 (Date rec'd by Registrar) (b) Huntington Willi... Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10- 1945 at 5.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23- 1945 to 4-10- 1945, and that I last saw him alive on 4-10- 1945.

Immediate cause of death: Pulmonary tuberculosis bilateral — Duration: 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Allen

Address Balt. City Hosp Date signed M. 4/13/45 D.

627781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. 627781

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mumma's Ave & Rutland Ave
(c) Hospital or institution: Lemon Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5833 Pk Hgts Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Arthur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-1943

8. AGE: Years 2 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER / FATHER

12. Name Abraham D. Arthur

13. Birthplace Balto.

14. Maiden Name Bernice Oellrich

15. Birthplace Balto.

16 (a) Informant Abraham D. Arthur

(b) Address 5833 Pk. Hgts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-45 (month) (day) (year)

(c) Cemetery or crematory Loudale

Location

18 (a) Funeral director Jos. Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date received by Local Registrar) Huntington Williams M.D.

APR 11 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1945, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1945 to 4-10 1945 and that I last saw h[illegible] alive on 4-10 1945.

Immediate cause of death: Respiratory arrest — Duration

Due to: Anaesthetic shock

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Leonard Lueken M.D.

Address Lemon Hosp. Date signed 4-10-45

RESERVED FOR RECORDING MARG

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

627782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Llewyn Ave:
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 : 0 : 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Llewlyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Roy Irvin Turner

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-0598

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Turner

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) January 11, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	-	hr. min.

9. Birthplace: Springfield, Ohio (Town, county, and state)

10. Usual Occupation: S. A. Williams Paint Co.

11. Industry or business

FATHER
12. Name: Elmer T. Turner
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Irene Leffel
15. Birthplace: Ohio

16 (a) Informant: Catherine Turner
(b) Address: 1628 Llewlyn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14, 1945 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Ellsworth Armacost
(b) Address: 3911 Liberty Hghts Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

VS APR 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 7 30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 8/7

(a) Date of injury April 11 1945 at 7 A. M.
(b) Where did injury occur Bond & Hoffman Sts
(c) Did injury occur at home, on farm, industrial place, in public place? R.R. Tunnel While at work? No
(d) Means of injury Fall from Top of Tunnel.

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed April 11 1945

G27783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G27783 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2911 Markley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Markley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace B. Hall Kachele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Clarence E. Kachele
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) April 17, 1915

8. AGE: Years	Months	Days	If less than one day
29	11	24??	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Sect'y.
11. Industry or business

FATHER
12. Name Robert B. Hall
13. Birthplace Balto.

MOTHER
14. Maiden Name Carrie I. Bortner
15. Birthplace Pa.

16 (a) Informant Mrs. Carrie I. Hall
(b) Address 2911 Markley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1800 Eutaw Place

19 (a) APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1942 to April 9 1945, and that I last saw her alive on April 9 1945.

	Duration
Immediate cause of death Coronary Occlusion	2 hours
Due to Auricular fibrillation	
Due to Rheumatic heart	10 years
Other Conditions Associated decompensation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harrold M.D. M.D.
Address 4706 Harford Road Date signed 4/10/45

8:30 A.M-10 X 6-8 P.M

627784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

627784 Registered No.

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 N. Bay St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Rev. William B. Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1898

8. AGE: Years	Months	Days	If less than one day
47	2	3	hr. min.

9. Birthplace..... (Town, county, and state)
10. Usual Occupation Preacher
11. Industry or business

FATHER 12. Name ?
13. Birthplace South Carolina

MOTHER 14. Maiden Name Junie ?
15. Birthplace South Carolina

16 (a) Informant Lalell Young
(b) Address 1046 Penka ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) APR 11 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1945, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aortic Insufficiency

Due to.....

Other Conditions Hypertrophy & dilatation of heart. Small amount of (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed 4-10-45

VS 151

G27785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27785

JO #89590

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME George Gorley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20, 1889

8. AGE:	Years	Months	Days	If less than one day
	55	8	10	..... hr. ..... min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Cline
15. Birthplace Pennsylvanie

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a)..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory.....
Location.....

JOHN HOPKINS MEDICAL SCHOOL APR 11 1945

18 (a) Funeral director Commissioner of Health ....
(b) Address.....

19 (a) APR 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1945, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1944, to Mar. 30, 1945, and that I last saw him alive on Mar. 30, 1945.

	Duration
Immediate cause of death Central Hemorrhage	1 hr.
Due to Central Contusion and Hypotension	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: no post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....
23. Signature [illegible] M. D.
Address Baltimore City Hosp. Date signed 4-5-45

1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

AB-627786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G27786 46 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. None (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William F. Curry

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-28-1876

8. AGE: Years	Months	Days	If less than one day
68	6 X	13	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William F. Curry
13. Birthplace Baltimore-Md.

MOTHER
14. Maiden Name Elizabeth Garrison
15. Birthplace Baltimore-Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14-1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md
18 (a) Funeral director Huntington Williams
(b) Address 2334 N Charles St

19 (a) (Date received by registrar) APR 11 1945 Huntington Williams (Signature of registrar)

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11- 1945, at 8.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5- 1945 to 4-11- 1945, and that I last saw him alive on 4-11 1945.

Immediate cause of death	Duration
Carcinoma Stomach	?
& metastases lungs	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-15-45
Major findings of operation: alone Inoperable
of autopsy: alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto City Hosp. Date signed 4-11-45

X

G27787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G27787
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST Joseph's Hospital 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13da.
(e) Length of stay in Baltimore (yrs., mos., or days) 49yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 E. Oliver Street.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah E. Boughter.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-6590

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alice O. Boughter
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 10-15-1879

8. AGE: Years	Months	Days	If less than one day
65	5	26	hr. min.

9. Birthplace Hartford County
(Town, county, and state)

10. Usual Occupation Iron-Worker

11. Industry or business

FATHER
12. Name James F. Boughty
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Jane Boyd
15. Birthplace Harford Co. Md.

16 (a) Informant Alice O. Boughter
(b) Address 308 E. Randall St

17 (a) Buried (b) Date thereof 4-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave & Miller Lane

18 (a) Funeral director Thos. J. Riley
(b) Address 2435 E. Oliver St

19 (a) APR 11 1945 (b)
(Date rec'd by registrar) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1945 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1945 to 4-10 1945 and that I last saw him alive on 4-10 1945

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Pneumonia	
and Meningitis	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Cullen M. D.
Address St Joseph's Hospital Date signed 4-10-45

G27788 ✓ G27788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 N. Eutaw Pl.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 427 N. Bradford St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Anna Clark

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1857

8. AGE: Years	Months	Days	If less than one day
88	1	23	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Joseph Clark

13. Birthplace England

MOTHER

14. Maiden Name Mary M. Bruges

15. Birthplace England

16 (a) Informant Barbara Bogner

(b) Address 427 N Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location Woodlawn Md

18 (a) Funeral director John G. Hoban

(b) Address 3000 E. Baltimore St.

19 (a) (Date received by Registrar) APR 11 1945 Huntington Williams, M.D. Registrar

VS-169

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 12 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945, to Apr. 9 1945, and that I last saw h[er] alive on Apr. 9 1945.

Immediate cause of death	Duration
Myocarditis	
Due to Advanced Arteriosclerosis	
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis Jacobs M. D.

Address 1700 Eutaw Place Date signed Apr. 9-1945

(17) X

G27789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115 B

G27789 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 E. 38th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and name town)
(d) Street No. 538 E. 38th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mae Cecelia Hatton

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Henry Hatton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7-1893

8. AGE: Years 51 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Wm. J. McLaughlin
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary E. Boyle
15. Birthplace Balto. Md.

16 (a) Informant Harry Hatton
(b) Address 538 E. 38th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-45 (month) (day) (year)
(c) Cemetery or crematory Woo. Balto.
Location Old Frederick Rd.

18 (a) Funeral director John G. McLean
(b) Address 800 E. Balto St.

19 45 (b) (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 18 1945 to April 9 1945; and that I last saw h[illegible] alive on April 8 1945

Immediate cause of death	Duration
Pulmonary Embolism	Sudden
Arteriosclerosis	2 days
Due to Bronchopneumonia	16 days
Due to Streptococcus viridans Bacteremia	18 days
Due to	3/30
Other Conditions	3/18 3/31

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George L. DeLeffey M. D.
Address 534 S. Patterson Park Date signed 4/11/45

VS 150

1

G27790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G27790 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 N Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 N Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sylvester J. Hutchins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1875

8. AGE: Years 70 | Months - | Days 9 | If less than one day hr. min.

9. Birthplace Conn (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name ?
13. Birthplace Conn

MOTHER
14. Maiden Name ? Losey
15. Birthplace Va

16 (a) Informant E J Hutchins
(b) Address 504 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director John C Yoder
(b) Address 3800 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1945 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Apr. 4 1945 to Apr. 10 1945 and that I last saw h. alive on Apr. 10 1945

Immediate cause of death: Coronary Occlusion — Duration 4 hrs
Due to: Chr. Myocarditis — 2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E. Dixon
Address 3 W. Biddle Date signed April 10 1945

G27791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27791 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR B[illegible]DING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 N. Calvert
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V. Talbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation none

11. Industry or business -

FATHER
12. Name Charles H. Bird
13. Birthplace N. J.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Charles N. Bird
(b) Address 2234 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) 4-7-45 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1945 at M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-11-45

VS 151

G27792

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G27792

CERTIFICATE OF DEATH 83D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Hurlbugh (If outside city or town limits, write RURAL and give town)
(d) Street No. Woodbrooks home. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mae Cecile Cunningham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife None.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6 1891

8. AGE: Years	Months	Days	If less than one day
54	0	4	hr. min.

9. Birthplace Connecticut (Town, county, and state)
10. Usual Occupation governess
11. Industry or business

FATHER
12. Name William Bradshaw
13. Birthplace Conn

MOTHER
14. Maiden Name Katherine Cunningham
15. Birthplace Ireland

16 (a) Informant Lt. Col. D. Symonds
(b) Address Woodbrook home Hurlbugh Md.

17 (a) Burial (b) Date thereof 4/13/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1945 at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1945 to 4-10 1945.
and that I last saw h m alive on 4-10 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Septicemia	
Due to	
Other Conditions Hemiplegia (left)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Mountcastle Jr. M. D.
Address 327 E. University Pkwy Date signed 4/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

24a

G27793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G27793

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Balt. General Hospl
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Edson St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Thomas Culp

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 9 1945

8. AGE: Years | Months | Days: 2 | If less than one day: ....hr. ....min.

9. Birthplace West Balt. Gen. Hospital (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Dallas Floyd Culp
13. Birthplace Wagner - Oklahoma

MOTHER
14. Maiden Name Mary Elizabeth Page
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Glennia Bailey
(b) Address 1096 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Gilbert Funeral Home
(b) Address 1400 Pennsylvania Ave

19 APR 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1945 to 4/11 1945, and that I last saw h. in alive on 4/11 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Anemia (Secondary)	
Due to Premature Separation Placenta (1/3 Separated)	
Other Conditions Bilateral parietal Cerebral Hemorrhage (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation: Bloody L.P. Large Sub-Pinnal Hematoma Rt Parietal
of autopsy: Massive Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Edward C. Day M.D.
Address West Balto Gen Hosp Date signed 4/12/45 M. D.

G27794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G27794

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3847 Quarry Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3847 Quarry Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Griffith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: John T. Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar 23rd 1860

8. AGE: Years: 85 | Months: 0 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs James Griffith
(b) Address: 3847 Quarry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/13/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~: St. Mary's
Location: Hamden

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) 4-13-45 (Date rec'd by registrar) (b) Huntington Williamette, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1945 at 11:30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to April 11 1945 and that I last saw h.er alive on 4-11 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4-11-45
Due to: Hypertension CVD — 7
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Lawrence Flemmard MD
M. D.
Address: 3711 Dallas Rd Date signed: 4-11-45

X Flemmard

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27795 Pennsylvania

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G27795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 N. Castle r
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N Castle r
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Grill

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Grill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1868

8. AGE: Years 76 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Austria Hungary (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

FATHER
12. Name John Grill
13. Birthplace Austria Hungary

MOTHER
14. Maiden Name Mary Snathouse
15. Birthplace Austria Hungary

16 (a) Informant Mary Grill
(b) Address 916 N Castle st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-45 (month) (day) (year)

(c) Cemetery or crematory Immaculate Conception
Location Somerville N. J.

18 (a) Funeral director Frank Brocki & Son
(b) Address 900 N. Chester st

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 180 APR 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1945, at 6A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945 to April 11 1945, and that I last saw him alive on April 10 1945

Immediate cause of death: Carcinoma of Stomach — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2201 E Madison st Date signed 4/11/45

X

627796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

627796 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Chaffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie Antonette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1898

8. AGE: Years: 46 | Months: 11 | Days: 24 | If less than one day: hr. min.

9. Birthplace Victoria Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER — 12. Name Yorman Chaffin

FATHER — 13. Birthplace Va

MOTHER — 14. Maiden Name unknown

MOTHER — 15. Birthplace

16 (a) Informant Marie Antonette Chaffin

(b) Address 1004 Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary And.

Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott Dept.

(b) Address 1297 N. Caroline

19 (a) APR 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945, at 7 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1945 to 4/10 1945, and that I last saw h.m. alive on 4/10 1945

Immediate cause of death: Rheumatic Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr.

Address Provident Hospital Date signed 4-14-45

X

627797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

627797 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Huntingdon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Huntingdon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Watts.

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife John T. Watts
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1878

8. AGE: Years	Months	Days	If less than one day
67	1	25	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm T. Chaney.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Sarah Sewell.
15. Birthplace Maryland

16 (a) Informant John T. Watts
(b) Address 2816 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/45 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Reisterstown, Md.

18 (a) Funeral director Chenault & Donovan
(b) Address 3615-17 Chestnut Ave.

APR 12 1945 (Date accepted by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to Apr 9 1945, and that I last saw alive on Apr 9 1941

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Arteriosclerosis ? ?

Due to

Other Conditions Valvular heart disease, Laparotomy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H. Calvert M. D.
Address 516 Pratt St Date signed 4-13-45

93a Culver

G27798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G27798

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 619 S. Patterson Pk Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 619 S. Patterson Pk. Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Cecilia Gibula

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Walter Gibula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15/15

8. AGE: Years	Months	Days	If less than one day
29	10	25	hr. min.

9. Birthplace Carlisle Pa (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name George Leonhartt

13. Birthplace Pa

MOTHER

14. Maiden Name R Dunbar

15. Birthplace Carlisle Pa.

16 (a) Informant Walter Gibula

(b) Address 619 S. Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore

18 (a) Funeral director Fred W. Ozazewski

(b) Address 1930 Eastern Ave

19 (a) (Date received by registrar) APR 12 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945 to April 9 1945 and that I last saw h[illegible] alive on April 9, 1945

Immediate cause of death	Duration
Lobar Pneumonia right base	Late
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ernest Lenn

Address 601 N. Broadway Date signed 4/11/45

G27799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27799

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 E. Preston St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Retlaw

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter Retlaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1886

8. AGE: Years 58 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Frederick Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mr. Walter Retlaw
(b) Address 928 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location End E. North Ave

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) Received and registered (b) Huntington Williams M.D.
APR 12 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945, at 8 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28-1944 to 4-10-1945; and that I last saw her alive on 4-9-1945.

Immediate cause of death: Hypertensive Cardiac Disease — Duration: Unknown
Due to:
Due to:
Other Conditions: Arteriosclerosis — 2 years.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Seybert M. D.
Address 2807 Harford Rd Date signed 4-11-45

G27800 BALTIMORE CITY HEALTH DEPARTMENT G27800
Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 S. Rosedale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County Carroll Co.
(c) City or town Union Bridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. XXXXXXXXXXXX
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife. Adam T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30-1891

8. AGE: Years 54 | Months 0 | Days 11 | If less than one day ____hr. ____min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John W. Arbaugh

13. Birthplace Md

MOTHER 14. Maiden Name Ann Brown

15. Birthplace Md

16 (a) Informant Winifred L. Brown

(b) Address 13 S. Rosedale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 13-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Roth Cr B. M. Walter City

18 (a) Funeral director Frank Stricker Sons

(b) Address

19 (a) Apr 12 1945 (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1945, at 11:50 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.

Date signed 4/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Myra St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Daniel L. Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-81

8. AGE: Years	Months	Days	If less than one day
63	6	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William J. Quinn

13. Birthplace Portland Baltimore Md.

MOTHER 14. Maiden Name [redacted] Murphy

15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director L. J. Rusch

(b) Address 530 E Oxford St.

19 (a) APR 12 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1945, at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1945, to 4-10 1945, and that I last saw h[illegible] alive on 4-10 1945

Immediate cause of death: Septic pyARTHROsis left hip — Duration: 3 Mos.

Due to hemolytic staph. Aureus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation MAR 26 1945

Major findings of operation: Septic pyarthrosis Left hip

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles J. Brosius M. D.

Address Johns Hopkins Hosp. Date signed 4-10-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 309

G27802 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st.St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7811 Tilmont Ave., B
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Harry Frost Claypoole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Claypoole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15,1870

8. AGE: Years	Months	Days	If less than one day
74	11	29 26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Steward -Retired-
11. Industry or business Seafaring

FATHER
12. Name George W. Claypoole
13. Birthplace Balto.,Md.

MOTHER
14. Maiden Name Elizabeth Bramble
15. Birthplace Balto.,Md.

16 (a) Informant Records,U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 4-14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Roche
(b) Address 5305 Harford Rd.

19 (a) Signature of local registrar Hunter Williams

APR 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 4:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar.30 1945, to Apr.11 1945, and that I last saw him alive on Apr. 11 1945.

Immediate cause of death	Duration
Arteriosclerotic heart disease	Unk.
Due to Arteriosclerosis general	Unk.
Other conditions: senility, diabetes mellitus, positive blood serology(Eagle Test)	
Other Conditions duodenal ulcer;diverticulosis of colon; hernia	

(Include pregnancy within 3 months of death)
Date of operation none done
Major findings of operation:
of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence (over) at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. Van Ackeren M. D.
Address U.S Marine Hospital Baltimore, Md. Date signed 4/11/45

J. F. VAN ACKEREN 93 D

G27803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

142 ✓

Registered No. G27803

MARK RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days) 2½

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 44th St (If rural give location with reference to main road)
(e) Citizen of foreign country? (Yes or No) Pontiac
If yes, name country

3 (a) FULL NAME Lonnie L. Hatley.

3 (b) If veteran, name war

3 (c) Social Security Account No. 719-10-6479

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Boiler Maker

11. Industry or business Garfield S. Bldg

FATHER
12. Name John Hatley
13. Birthplace Md.

MOTHER
14. Maiden Name –
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12th 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Salisbury Md.

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 APR 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945, at 7:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D. (Medical Examiner.)
Date signed 4-10-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G27804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St Paul opp. Int Light St Pad (If rural give location)
(e) Citizen of foreign country — No — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Beulah P. Smallwood

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-62-2725

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1885

8. AGE: Years 60 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Philip S. W. Smallwood
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Emma Parker
15. Birthplace Bellsville Md

16 (a) Informant Mr. Willard R. Smallwood (Son)
(b) Address 104 Gale Drive - Silver Spring Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-13-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Steward Mortuary
(b) Address 108 W Mosher

19 APR 12 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-45 19 , at 3 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20-45 19 , to 4-11-45 19 , and that I last saw her alive on 4-11-45 19

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to Ca of Uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 4-11-45

X

G27805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G27805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 E. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 E. Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25, 1904

8. AGE: Years	Months	Days	If less than one day
41	0	10	hr. min.

9. Birthplace Brunswick, Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Bonnie Walker
13. Birthplace Brunswick, Va

MOTHER
14. Maiden Name Frances Goodrich
15. Birthplace Brunswick Va

16 (a) Informant Alice Evans
(b) Address 1001 E. Lexington

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)
(c) Cemetery or crematory Brunswick
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

APR 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 10 1945, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1945, to Apr 10 1945, and that I last saw h[illegible] alive on Apr 6 1945

Immediate cause of death	Duration
Malignant Melanoma of little toe, right foot.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 1944
Major findings of operation: Johns Hopkins Hospital
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Edward Fisher M.D.
Address 1612 E Monument Date signed Apr 13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 250

G27806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G27806

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 E 21 1/2 St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. 21 1/2 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Mickens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-22-1906

8. AGE: Years	Months	Days	If less than one day
38 39	3	17	hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Frank Hopkins

13. Birthplace Md

MOTHER 14. Maiden Name Evlini Anderson

15. Birthplace Md

16 (a) Informant Thomas Mickens

(b) Address 333 E 21 1/2 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location a. a. Co

18 (a) Funeral director Paynes Sanders

(b) Address 1412 E Preston St

19 APR 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 11 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 44 to April 9 1945 and that I last saw h[illegible] alive on April 9 1945.

Immediate cause of death

Bronchopneumonia

Due to

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Dennis M. D.

Address 4700 W 13th E. 33rd St Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

Registered No. G27807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: mercy hosp.
(c) Hospital or institution: mercy hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 11
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Balto
(c) City or town: Balt Gundah
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 4 Kentway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Baby girl Kirby -

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-2-45

8. AGE: Years | Months | Days: 9 | If less than one day: hr. min.

9. Birthplace: Balt - Md -
(Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: Alfred Kirby
13. Birthplace: Jacksonville Florida

MOTHER
14. Maiden Name: Mary Cy Teet
15. Birthplace: Centre, Dubois -

16 (a) Informant: Mrs. Kirby -
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/12/45 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: Seaman Mill Rd.

18 (a) Funeral director: John J Connelley
(b) Address: 418 Fontaine Ave.

19 (a) (State or country) (b) Huntington Williams, M.D. Registrar

APR 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 11 19 45 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 19 45 to 4-11 19 45
and that I last saw h alive on 19

Immediate cause of death: atelectasis
resp. failure -

Duration:

Due to:

Due to:

Other Conditions: pneumonia -
(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: W Deane W. Osborne M. D.
Address: Mercy hosp. Date signed: 4-11-45

X

627808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 627808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARG RESERVED FOR B DING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Bay. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Durham Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1908

8. AGE: Years	Months	Days	If less than one day
36	9	4	hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Andrew Johnson
13. Birthplace Alabama

MOTHER
14. Maiden Name Allie Woods
15. Birthplace Alabama

16 (a) Informant Edith Johnson
(b) Address 420 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto County Md

18 (a) Funeral director Mrs. Robert V. Elliott
(b) Address 1129 N. Calvert St Baltimore, Md

19 (a) APR 12 1945 (Date received) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8- 1945, at 8:25 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Silicosis

Due to

Other Conditions Pneumonia, Tuberculosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Anderson M.D. Medical Examiner.
Date signed 4-9-45

VS 151

G27809

471497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G27809

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Skinner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-14-27

8. AGE: Years	Months	Days	If less than one day
17	10	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jordan Skinner
13. Birthplace N C

MOTHER
14. Maiden Name Sarah Stanley
15. Birthplace Baltimore Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 12-45 (month) (day) (year)
(c) Cemetery or crematory Auburtus memorial
Location Auburtus Md

18 (a) Funeral director Robert E Watkins
(b) Address 1515 McElderry St

19 (a) APR 12 1945 Hunting for Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 2:10 P.M. A

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1945 to April 9 1945, and that I last saw h[er] alive on April 9 1945

Immediate cause of death	Duration
Generalized Tuberculosis	Years
+ Tbc of Spine + Wrist	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Feb 1945

Major findings of operation: Biopsy of Wrist – Tbc Granulations

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Alan C. Woods M.D.

Address Johns Hopkins Hospital Date signed 4/9/45

627810
JL - 91451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. 627810

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1896

8. AGE: Years	Months	Days	If less than one day
48	5	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Briscoe
13. Birthplace Md.

MOTHER
14. Maiden Name Charity Tabbs
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Preastmans St

19 (a) APR 12 1945 (Date rec'd) (b) Huntington Williams, M.D. Registrar

VS 150 SUBJECT TO APPROVAL OF MEDICAL EXAMINER: 4/12/45 Approved: Hugh P. McGalley M.D. per Robert Emerson M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 10 1945 at 8.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1945, to Apr. 10 1945, and that I last saw her alive on Apr. 10 1945.

Immediate cause of death Congestive heart failure. — Duration 7

Due to Sy[illegible] heart disease

Due to

Other Conditions Chronic joint Fracture Lip left. 7 Yrs. — 3

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence 2-4-45 M
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? B C H (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 4-11-45

G27811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

Registered No. G27811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 Scott St
(c) Hospital or institution: N

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Fitzc FITZE

3 (b) If veteran, name war

3 (c) Social Security Account No.

E.R. **MEDICAL CERTIFICATION**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18. 1894

8. AGE: Years	Months	Days	If less than one day
50	7	23	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Chas. G. Brandt. Inc

FATHER 12. Name Amos Fitze

13. Birthplace Md

MOTHER 14. Maiden Name Liza C. Mentzode

15. Birthplace Md

16 (a) Informant John H. Fitze

(b) Address 223 Scott St

17 (a) Burial (b) Date thereof Apr 12. 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Benjamin Luth Church

Location Westminster Md

18 (a) Funeral director Mr. Mrs. John H. Deifel & Son

(b) Address 801 W. Fayette St

19 (a) APR 12 1945 Huntington Williams, M.D.
(Date received by registrar)

20. DATE OF DEATH 4/10 19 45 at 3:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B McDaniel M.D.
Medical Examiner.

Date signed 4/17/45

VS 151

G27812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G27812 Registered No. 7310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 N. ~~Penny~~ Parrish St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. ~~Penny~~ Parrish St. (If rural, give R.F.D.)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Myrtle Brafton

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6/1904

8. AGE: Years	Months	Days	If less than one day
40	11	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Murray
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Md

16 (a) Informant Mabel Davenport (Daught~~er~~)
(b) Address 206 N. Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) (Date received by Registrar) APR 12 1945 Hunting for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1945 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-Vascular Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR R DING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G27813

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2327 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret A. McIntire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 1864

8. AGE: Years 81 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER | 12. Name Owen McIntire
13. Birthplace Ireland

MOTHER | 14. Maiden Name Catherine Tunney
15. Birthplace Ireland

16 (a) Informant Miss Alice McIntire
(b) Address 2327 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)
(c) Cemetery or crematory St. Marys Seminary
Location Baltimore Md.

18 (a) Funeral director Martin Eglenton
(b) Address 1827 N. North Ave.

19 (a) Received by (b) Huntington Williams M.D. Registrar

APR 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1945 to April 10 1945, and that I last saw h[illegible] alive on April 9 1945.

Immediate cause of death	Duration
Arteriosclerosis	1940
Chr. Myocarditis	1940
Due to Senile Dementia	1944
Chr. Ul. Nephritis	1943
Due to Senile Dementia	
post	
Other Conditions Toxemia	1945

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. W. Bishop M. D.
Address 501 Sheridan Ave. Date signed April 10 45.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27814 G27814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rubeland St. & Ramona Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Lauretta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elvira Carnapali Elvira Corropoli

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Ercole Corropoli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27 1897

8. AGE: Years	Months	Days	If less than one day
47	7	15	hr. min.

9. Birthplace Ururi Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Antonio Corvinelli
13. Birthplace Italy

MOTHER
14. Maiden Name Carolina Occhionero
15. Birthplace Italy

16 (a) Informant Ercole Corropoli (Husband)
(b) Address 2517 Lauretta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) APR 12 1945 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 11 1945, and that I last saw h.e.r. alive on April 11 1945.

Immediate cause of death	Duration
Uremia	
Due to Chronic Pyelonephritis	
Due to	
Other Conditions Hypertensive Cardiovascular Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunt B. Buchanan M.D.
Address West Baltimore General Hospital Date signed 4/12/45

133 L

G27815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G27815

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N Curley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F Berntheusel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 1880

8. AGE: Years	Months	Days	If less than one day
64	5	9 10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Frieght Handler

11. Industry or business

FATHER
12. Name William Berntheusel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Fisher
15. Birthplace Germany

16 (a) Informant Mrs Marie Luber
(b) Address 407 N Curley St

17 (a) Burial (b) Date thereof April 13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetry
Location Baltimore Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

APR 12 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1945 to 4-10 1945 and that I last saw h alive on 4-10 1945

Immediate cause of death Cerebral Hemorrhage

Due to Senility

Due to Hypertension

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Fatal

of autopsy

Duration: 1 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Fred Boyd M. D.

Address 409 N Eutaw Date 4-11-45

Stetter

G27816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G27816 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 416 S Clinton St

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 6

(e) Length of stay in Baltimore (yrs., mos., or days) Life V

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 416 S Clinton St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Stetter, Evelyn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) May 15 1903

8. AGE: Years 42 | Months 10 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business Erlanger Bros

FATHER

12. Name William Stetter

13. Birthplace Baltimore

MOTHER

14. Maiden Name Margaret Wissner

15. Birthplace Baltimore

16 (a) Informant Miss Marie Stetter

(b) Address 416 S Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004-8 Orleans St

19 APR 12 1945 (Date received by) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1945, at 11 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1945, to 4-10 1945, and that I last saw Mrs alive on 4-10 1945

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Thrombocytopenic purpura

Due to Hypochromic anemia Etiology unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jerome R. Harlan M. D.

Address Sinai Hospital Date signed 4-12-45

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 E. 33rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** PAUL HERMAN SCHWARTZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clara May Collins
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	15	____ hr. ____ min.

9. Birthplace Mason, W. Va.
(Town, county, and state)
10. Usual Occupation Cafe Proprietor
11. Industry or business

FATHER
12. Name Edward Schwartz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Clara M. Schwartz
(b) Address 826 E. 33rd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)
(c) Cemetery or crematory Beech Grove Cem.
Location Pomeroy Ohio.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Huntington W. Va.

APR 12 1945
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1945 at 5.12 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1-45 to 4-11-1945. and that I last saw [illegible] alive on April 10 1945.

Immediate cause of death	Duration
General Arteriosclerosis	8 yrs
Cerebral Hemorrhage	1 yr
Coronary Thrombosis	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon M.D.
Address 129 S Burley Date signed 4/13/45

G27818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27818 Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Watson Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Wallace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER: 12. Name.....
13. Birthplace

MOTHER: 14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL APR 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 12 1945 (Date rec'd by registrar) (Signature) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945, at 11 30 A. M

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed March 23 1945

2646

G27819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G27819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 W. 20th St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Rhaynelda Waters

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHNS HOPKINS MEDICAL SCHOOL APR 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 APR 12 1945 (Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945, at 8 40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Frater M.D.
Medical Examiner.
Date signed March 21 1945

VS 151

2047 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√61

G27820

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2852 W. North ave.

(c) Hospital or institution: 15"

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County ---

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2852 W. North avenue

(If no street address, give descriptive location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME MARY A. WILSON

3 (b) If veteran, name war --

3 (c) Social Security Account No. 705-03-7572

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1873

8. AGE: Years 71 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Clerk B. & O. R.R.

11. Industry or business

FATHER

12. Name Archibald Wilson

13. Birthplace Ireland

MOTHER

14. Maiden Name Jane Ritchie

15. Birthplace Phila. Pa.

16 (a) Informant Miss Nellie Wilson

(b) Address 2852 W. North avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Chas. J. Gray Son Inc

(b) Address 118 W. Mt. Royal Ave

19 (a) APR 12 1945 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1942 to April 10 1945, and that I last saw h[illegible] alive on April 10 1945

Immediate cause of death	Duration
Cerebral Hemorrhage.	3 hours
Blood pressure 265 of 9 Mm.	
Due to Arterial Sclerosis	10 years
Due to Diabetes for	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —

(Specify type of place)

(e) Means of injury —

23. Signature Herbert E. Zepp M. D.

Address 3048 W. North Ave Date signed 4/4/45

Baltimore 16 Maryland

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G27821 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 E. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie Kleszynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Kleszynski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years 63 62. | Months | Days | If less than one day hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Wessell

13. Birthplace Poland

MOTHER 14. Maiden Name ? ?

15. Birthplace ? ?

16 (a) Informant: Friends

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cemetery

Location German Hill Road

18 (a) Funeral director Mary Weber

(b) Address 401 S. Chester St.

APR 13 1945 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1945, at 4.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945, to April 10 1945, and that I last saw her alive on April 10 1945.

Immediate cause of death: Coronary occlusion — Duration: 1 day

Due to:

Due to:

Other Conditions: Diabetes mellitus — 7 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattan, M.D.

Address Johns Hopkins Hosp. Date signed 4/10/45

94a

G27822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G27822

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Rathland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country U. S.

3 (a) FULL NAME Jacob Landes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Issac Judah
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Rifka
15. Birthplace Russia

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)
(c) Cemetery or crematory Beth David
Location Long Island N.Y.

18 (a) Funeral director Jacob Levy Inc.
(b) Address 1439 E. Baltimore St.

19 (a) Date received APR 13 1945 (b) Registrar Huntington Williams M.D. Registrar

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/45 19 , at 4.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1944 to April 12 1945 and that I last saw h[illegible] alive on 4/12 1945

Immediate cause of death Cardio-Resp. failure — Duration

Due to Hypertension-Arteriosclerosis, Chronic Nephritis

Due to Generalized arteriosclerosis Cardio decompensation

Other Conditions Myocardial insuff.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley A. Hirsh M.D.

Address Sinai Hospital Date signed 4/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 Windsor Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amy M. Quayle

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Augustus Quayle

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 1st 1886

8. AGE: Years 58 | Months 6 | Days 10 | If less than one day: hr. min.

9. Birthplace: Kingston, Jamaica, W. I.
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: Frederick Edwards
13. Birthplace: Jamaica

MOTHER
14. Maiden Name: Ellen (Unknown)
15. Birthplace:

16 (a) Informant: Mrs L. Lucas
(b) Address: 1701 Ashburton st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/14/45 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st.

19 (a) (Date received by local registrar) APR 13 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11th 1945, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944, to April 11 1945, and that I last saw he alive on April 11 1945.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. E. Schmidt M. D.
Address 2424 Brighton st Date signed 4-12-45

X

G27824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G27824

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Wheatsheaf
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Woodbrook Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Blanche Wormser (Blanche Wormser)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem.

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel Wormser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1887

8. AGE: Years 57 | Months 4 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Abraham Brettingfs

13. Birthplace Germany

MOTHER Cecelia Bettering

15. Birthplace Germany

16 (a) Informant Husband (Signed)

(b) Address 3500 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45. (month) (day) (year)

(c) Cemetery ~~or crematory~~ Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director Edwin Sonneborn & Son

(b) Address 202 Eutaw Place

APR 13 1945 (a) (Accepted by registrar) (b) Huntington Williams M.D. (Registrar)

VS 180

— over —

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1945, at 9:45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 1945 to Apr 11 1945 and that I last saw h.. alive on Apr 11 1945

Immediate cause of death Cerebral Edema

Duration

Due to ? Cancer of Stomach Colon & metastases &

Due to Intestinal Obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr 7 1945

Major findings of operation: Collapsing of bowels & strangulation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Haymaker M. D.

Address Md Devil Head Date signed 4/11/45

X

G27825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G27825 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Baker St.
(c) Hospital or institution: —
16-T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) nearly 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Baker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Louise Breyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10 1874

8. AGE: Years 71 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore County (Town) (Town, county, and state)

10. Usual Occupation Home work

11. Industry or business —

FATHER
12. Name Louis Breyer
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Schlegel
15. Birthplace Germany

16 (a) Informant Mrs. Manning Breyer (Sister)
(b) Address 3006 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) (Registrar) APR 13 1945 Henrietta Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945; at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1943 to April 11 1943 and that I last saw h[illegible] alive on April 11 1945

Immediate cause of death	Duration
Coronary occlusion	few minutes
Due to Hypertension	3 or 4 yrs.
Due to Chronic nephritis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bartus I Taggart M.D.
Address 3812 Fleetwood Ave. Date signed 4/11/45

G27826 Ha Dall

BALTIMORE CITY HEALTH DEPARTMENT X V G27826

CERTIFICATE OF DEATH 200 C Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severna Park - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Lerch Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-45

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Landren Duvall
13. Birthplace Severna Park Md.

MOTHER
14. Maiden Name Esther Ellen Mallonee
15. Birthplace Baltimore Md.

16 (a) Informant Mr Wm Duvall
(b) Address Severna Pk, Md

17 (a) Burial (b) Date thereof 4/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Henney Inc
(b) Address 715 Light St

19 APR 13 1945 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-45 19 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 19 45 to 4-12 19 45 and that I last saw h[illegible] alive on 4-12-19 45.

Immediate cause of death Undetermined — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Francis L Greenstone M. D.
Address Bon Secours Hosp Date signed 4/13/45

X

G27827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G27827

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 Belview Ave
(c) Hospital or institution:

15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Belview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Robson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara M. Robson

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) April 2/1871

8. AGE: Years	Months	Days	If less than one day
74		10	hr. min.

9. Birthplace Easton Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Brigham Hopkins Co

FATHER
12. Name Joseph S. Robson
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Massey
15. Birthplace Unknown

16 (a) Informant Clara M. Robson
(b) Address 4106 Belview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry D. Amoscott
(b) Address 4704 Ridgewood Ave

19 (a) (b) Huntington Williams, M.D. Registrar

APR 13 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1945 at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1944 to 4/12 1945 and that I last saw him alive on 4/12 1945

Immediate cause of death Cause of tongue

	Duration
Due to	14 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Russell M.D.
Address 3902 Greenwood Date signed 4/12/45

G27828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G27828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE IN SPACES RESERVED FOR BOOKING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Woodlea Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Sheldon

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-0344

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ruth E. Sheldon

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1906

8. AGE: Years 38 | Months 3 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Army Inspector

11. Industry or business U. S. Army

FATHER
12. Name William W. Sheldon, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Baker
15. Birthplace Baltimore, Md.

16 (a) Informant Ruth E. Sheldon
(b) Address 4005 Woodlea Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Howard N. Bight Jr.
(b) Address 4914 Belair Road

19 (a) [illegible] Registrar
APR 13 1945
Huntington Hollands, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 19 45 at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulmicki M.D. Medical Examiner.
Date signed 4/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27829

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3324 Calvert Sts.

(c) Hospital or institution: Union Memorial Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3/4 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3345 Paine St (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Stanley Sentz

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-7225

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Esther Sentz

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1897

8. AGE: Years	Months	Days	If less than one day
47	8	4	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Bel Mar Corp. Foreman

11. Industry or business

FATHER

12. Name George Sentz

13. Birthplace Maryland

MOTHER

14. Maiden Name ? Ritter

15. Birthplace Maryland

16 (a) Informant Esther Sentz

(b) Address 3345 Paine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Howard N. Blight, Jr.

(b) Address 4914 Belair Road

19 (a) (b)

(Registrar's signature)

APR 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945, to April 11 1945, and that I last saw him alive on April 11 1945

Immediate cause of death	Duration
Cardio - Respiratory Failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. W. Thompson Jr. M. D.

Address 332 E. University Pkwy Date signed 4/14/45

For C. J. Gibbons, Registrar by Howard J. Mallonee, M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G27830
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 4-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1752 N. Columbus
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS HURWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Hebr Relative
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pikesville Hamilton Ave

18 (a) Funeral director Jack Levine
(b) Address 1439 E. Baltimore

19 (Registrar's signature) APR 13 1945 Huntington Williams, M.R.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1945 to 4/12 1945
and that I last saw h[illegible] alive on 4/12 1945

Immediate cause of death Pulmonary edema — Duration

Due to Coronary Art Disease

Due to

Other Conditions Ca of Stomach & metastases
(Include pregnancy within 3 months of death)

Date of operation 4/2/45

Major findings of operation: ca of stomach

of autopsy: (yes or no)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 4/12/45

G27831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G27831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2720 AUCHENTORLY TER
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Same
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME SARAH PEARLSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife MANUEL PEARLSTEIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name HYMAN BINDER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ROSE RABINOVITZ
15. Birthplace RUSSIA

16 (a) Informant MRS. STELLA JACOBSON
(b) Address 2720 AUCHENTORLY TER

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Md

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTIMORE ST

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1945, at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1945, to 4-12 1945, and that I last saw her alive on 4-10 1945

Immediate cause of death Stated heart
general edema — Duration 6 Months

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Harry D. McCarty, M. D.
Address 37 W Preston St Date signed 4/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

3471 30 G27832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 c

Registered No. G27832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give county)
(d) Street No. 703 Washington Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Louis Dorsey Harris

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Ann

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-12-89

8. AGE: Years	Months	Days	If less than one day
55	9	0	..... hr. ..... min.

9. Birthplace Maryland-Daisy, Howard (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name William Harvey Harris
13. Birthplace Md

MOTHER
14. Maiden Name A. Griffith
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 13 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945 to April 12 1945, and that I last saw h[illegible] alive on April 12 1945

Immediate cause of death	Duration
Increasing Intracranial Pressure	4 wks
Due to Cerebral Metastases	
Due to Carcinoma (? Bronchogenic)	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Confirms Clinical Impression.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Laurence Richards M.D.
Address Johns Hopkins Date signed 4/12/45

X

DG27833

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131A

Registered No. G27833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 W La Fayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 La Fayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-18-1514

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George Thomas

6 (c) If wife, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov 22 1900

8. AGE: Years 44 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Macon Ga. (Town, County, and State)

10. Usual Occupation Sewing Machine Operator

11. Industry or business

FATHER 12. Name John Matthis
13. Birthplace Macon Ga.

MOTHER 14. Maiden Name Emma Perkins
15. Birthplace Ga

16 (a) Informant Emma Campbell
(b) Address 1335 W La Fayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Philadelphia
Location Pa

18 (a) Funeral director Mrs Katie R Wallace
(b) Address 3223 N Fulton Ave Huntington Williams, W Va

19 (a) APR 13 1945 (b) (Registered by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1945 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/1945 to 4/11/1945, and that I last saw h[illegible] alive on 4/11/1945

Immediate cause of death: Hypertensive Cardio Vas Renal Disease — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Savill M.D.

Address 100 N Carrollton Ave Date signed 4/12/45

G27834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27834

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 Ridgewood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Ridgewood Road
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Charles J. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Valerie Vogeler
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------

8. AGE: Years	Months	Days	If less than one day
About 57	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business -------

FATHER
12. Name Charles J. Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Schaur
15. Birthplace Maryland

16 (a) Informant John Brooks
(b) Address 614 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

APR 13 1945 (Date rec'd by registrar) (Huntington Williams M.D.) Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1945 at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1930 to 4/12 1945; and that I last saw him alive on 4/10/45

Immediate cause of death	a. Duration
Coronary Thrombosis	Immediate
Due to Hypertension & Arterio-Sclerosis	Confirmed
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. H. Reedy M. D.
Address 1403 Park Ave. Date signed 4/13/45

G27835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27835

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry C. Nearing

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary J. Nearing
6 (c) If alive, give age 70 years
MARY T.

7. Birth date of deceased (mo., day, yr.) Feb 28, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Md. Country Club

FATHER
12. Name Adam Nearing
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Margaret Roessler
15. Birthplace Germany

16 (a) Informant Mary J. Nearing
(b) Address 2003 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 16 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Wm. Mis. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 APR 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to April 11 1945 and that I last saw h[illegible] alive on April 11 1945

Immediate cause of death Arteriosclerotic Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Seagrott M. D.
Address 1729 W Lanvale St Date signed 4/13/45

VS 150

X

G27836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27836 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 W. University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 W. University Parkway
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country

3 (a) FULL NAME William Vion Masson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jessie L. Masson
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	2	hr. min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name William Masson
13. Birthplace Ohio

MOTHER
14. Maiden Name Ernestine Vion
15. Birthplace Missouri

16 (a) Informant Mrs. William V. Masson
(b) Address 807 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) APR 13 1945 (Registrar's Signature) Huntington Williams, M.D. (b) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1940 to April 11 1945.
and that I last saw h[illegible] alive on April 10 1945.

Immediate cause of death Pulmonary Oedema — Duration 1 da

Due to Cerebral Hemorrhage and Chronic Nephritis — Duration 8 yrs

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation /

Major findings of operation: /

of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence / at M
(c) Where did injury occur? / / /
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? / While at work? /
(Specify type of place) /
(e) Means of injury /

23. Signature Thos F Bloke M. D.
Address 20 E Preston Date signed 4/12-45

G27837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G27837

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Paca
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Mt. Elliott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Frederick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Poole

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-5250

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	22	hr. min.

9. Birthplace Woodbine, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Francis W. Poole
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Smart
15. Birthplace Phelps, Va.

16 (a) Informant Russell A. Poole
(b) Address Elliott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 15, 1945 (month) (day) (year)

(c) Cemetery or crematory Poplar Springs Cem.
Location Howard Co., Md.

18 (a) Funeral director C. Harry Dew
(b) Address Ilchester, Md.

19 APR 13 1945 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1945; at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1945 to 4/12 1945, and that I last saw h. alive on 4/12 1945.

Immediate cause of death: Diabetic Coma — Duration

Due to: Diabetes Mellitus

Due to:

Other Conditions: Pneumonia & pneumatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Kenly MD

Address Mine Bay Date signed 4/13/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Morse
3105 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT

G27838 CERTIFICATE OF DEATH 92 C

Registered No. G27838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Beechland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Beechland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice V. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Robert L. Fields
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1889

8. AGE: Years 55 | Months 7 | Days 3 4 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Griggs
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Unknown

16 (a) Informant Mr. Herbert L. Fields
(b) Address 7426 BrookwoodRoad #6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

APR 13 1945 (Date rec'd by Registrar) (b) Huntington-Williams, Inc.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th, 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to April 12 1945.
and that I last saw h[illegible] alive on 4-11 1945

	Duration
Immediate cause of death: Rheumatic valvular heart disease	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation –
Major findings of operation: –
of autopsy: –

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work? –
(Specify type of place)
(e) Means of injury –

23. Signature John Wm Morse M. D.
Address 3105 Belair Rd Date signed 4-13-45

X

Dr. M. B. Gre G27839
3009 Evergreen Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 830

G27839 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Mary Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Mary Avenue #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James A. Hogan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Cecelia J. Hogan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	21 20	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Newspaper Pressman
11. Industry or business

FATHER
12. Name John Hogan
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Cecelia J. Hogan
(b) Address 3025 Mary Avenue

17 (a) Burial (b) Date thereof 4/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 13 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th, 1945, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945 to April 11 1945 and that I last saw h[illegible] alive on April 11 1945.

Immediate cause of death	Duration
Right Hemiplegia	Apr 11/45
Cerebral Hemorrhage (Apoplexy)	
Due to	
Due to	A number of Years
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Green
Address 3009 Evergreen Ave Date signed 4/13/45
Baltimore 14 Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 783A

G27840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 1200 Valley St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Blecha

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9- 1849

8. AGE: Years: 96 | Months: -1 | Days: 3- | If less than one day: hr. min.

9. Birthplace: Bohemia Lith.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Little Sisters of the Poor
(b) Address: 1200 Valley St Govt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/16/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location

18 (a) Funeral director: Leonard J. Rivet
(b) Address: 5305 Belford Rd.

19 (a) 4/13/45 (Date rec'd by registrar) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12- 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1- 1945, to April 12- 1945, and that I last saw her alive on April 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days
Due to: Arterio-Sclerosis — 6 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: E Gill Hall M. D.
Address 1631 E North Ave Date signed 4/13/45

(over)

G27841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27841 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Chestnut Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Chestnut Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Harding

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No. 212-16-9658
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Jessie C. Harding
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17 1870
8. AGE: Years 75 Months 1 Days 25 If less than one day hr. min.
9. Birthplace Howard Co. Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Napoleon B. Harding
13. Birthplace Maryland

MOTHER
14. Maiden Name Theresa A. Dorsey
15. Birthplace Maryland

16 (a) Informant Mrs. Jessie C. Harding
(b) Address 3710 Chestnut Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Durpee Funeral Home
(b) Address 3431 Falls Road

19 (a) (Date received by Registrar) APR 13 1945 (b) Huntingtown, Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to April 12 1945, and that I last saw him alive on April 11 1945.

Immediate cause of death: Coronary occlusion — Duration 1 day.
Due to: Coronary Sclerosis & Heart disease — 2 years
Due to: generalized arteriosclerosis
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
898 N 36th St Date signed 4/14/45

G27842 J. ANDRE LOIZEAUX

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G27842

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Rosalie Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J. André Loizeaux
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 24-1935
8. AGE: Years 9 Months 8 Days 18 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Stanley G. Loizeaux
13. Birthplace New York

MOTHER
14. Maiden Name Marguerite L. Stansbury
15. Birthplace Maryland

16 (a) Informant Stanley G. Loizeaux
(b) Address 3014 Rosalie Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Co. Md.

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd) APR 13 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1945, at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1945, to 4/12 1945, and that I last saw him alive on 4/12 1945

Immediate cause of death: multiple hemorrhages — Duration

Due to Acute Lymphoid Leukemia, aleukemic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mark M. D.
Address Union Hosp. Date signed 4/12/45

VS 150

Dr Harold Harbold 4706 Harford Ave Balto 26 Md G27843

G27843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27843

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4617 Asbury Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4617 Asbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~ or ~~divorced~~: Married

6 (b) Name of husband or wife: John T. Murray Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31st 1877

8. AGE: Years	Months	Days	If less than one day
68	2	10	....hr. ....min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Chas. W. Morgan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Harriett A. Watton
15. Birthplace Balto. Md.

16 (a) Informant John T. Murray Sr
(b) Address 4617 Asbury Ave

17 (a) Burial (b) Date thereof 4/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Cremation~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St

19 (a) APR 13 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1945, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1945, to April 10 1945, and that I last saw h.er alive on April 6 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 hrs
Due to Hypertension (Malignant)	
Due to Coronary sclerosis Arteriosclerosis	
Other Conditions Hypertrophic arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M. D.

Address 4706 Harford Road Date signed 4/13/45

Held until called for by Wm x Cook. Inc

G27844 G27844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 Dudley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Dudley Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William T. Charnock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sarah E. Charnock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1866

8. AGE: Years 79 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Retired Boat Captain

11. Industry or business

FATHER
12. Name William Charnock
13. Birthplace Va.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Sarah E. Charnock
(b) Address 3105 Dudley Ave.,

17 (a) Burial (b) Date thereof 4-14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Date received by Registrar) APR 13 1945 (b) Registrar's signature Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 12, 1945, at 5.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1937 to Apr 12 1945, and that I last saw him alive on Apr 12 1945.

Immediate cause of death	Duration
Cardiac Failure	2 Days
Due to Chronic Cardiovascular Renal disease (Hypertension)	7 years
Due to	
Other Conditions Carcinoma - Kept (Cancer)	8-9 Mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry A Bayley Date signed 4/13/45

G27845 Reserve #3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 183

Registered No. G27845

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
Found Harbor East Fallsave + Pratt St 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(m) **FULL NAME** Unknown Black Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 35? Months Days If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY APR 12 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (Date rec'd by registrar) (Registrar)
APR 13 1945 Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7- 1945, at 10 30 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at ? 3-2 M.
(b) Where did injury occur? Harbor E. Fallsave. + Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found drowned

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-8-45

G27846 Grave #2 DAVIS G27846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flet ST
(c) Hospital or institution: Found Harbor pier #6 Pratt St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified Woman Mamie Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	

6 (b) Name of husband or wife Charles Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
35?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Schecks

13. Birthplace

MOTHER 14. Maiden Name Mary H Cheeks

15. Birthplace North Carolina

16 (a) Informant Police Dept.

(b) Address Baltimore City Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY APR 12 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 13 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury April at M.

(b) Where did injury occur? Pier #6 Pratt ST

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Found Drowned

23. Signature Robert L. Graham M.D.
Medical Examiner.

Date signed March 31 1945

VS 151

G27847

Reserve #1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G27847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Mem. Hosp.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 W. 26th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Roosevelt Sowers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12 1902.

8. AGE: Years 43 | Months 4 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation House painter

11. Industry or business

FATHER 12. Name Arch Sowers.

13. Birthplace Va.

MOTHER 14. Maiden Name Cora Grimes

15. Birthplace Virginia

16 (a) Informant Joseph A. Sh.

(b) Address 421 W. 26th ST Balto

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)

(c) Cemetery or crematory ____
Location PUBLIC CEMETERY APR 12 1945

18 (a) Funeral director Commissioner of Health

(b) Address ____

19 (a) APR 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 — 1 19 45 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1945 to 4-1 1945; and that I last saw him alive on 4-1 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Carcinoma Lung	
Due to ____	
Other Conditions ____	

(Include pregnancy within 3 months of death)

Date of operation 3-19-45

Major findings of operation: Inoperable Carc. L. Lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Melchijah Spragins M. D.

Address U. M. H. Date signed 4-1-45

VS 150

G27848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G27848

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 W. Pratt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Pilsch

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-45 @ 6.25 AM

8. AGE: Years	Months	Days	If less than one day
			1 hr. 35 min.

9. Birthplace Franklin Square Hospital (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Lena Pilsch
13. Birthplace Balto; Md.

MOTHER
14. Maiden Name William C. Pilsch
15. Birthplace Balto. Md.

16 (a) Informant Mother
(b) Address 1825 W. Pratt St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 13 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945 to April 11 1945 and that I last saw him alive on April 11 1945.

Immediate cause of death: Congenital Atelectasis — Duration

Due to: Premature 6 Months

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 4/11/45

651

G27849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27849 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 N. Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 N. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	7	hr. min.

9. Birthplace Lynchburg, Virginia
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Julia
15. Birthplace Va.

16 (a) Informant Sarah Evans
(b) Address 540 N. Mulberry St

17 (a) Burial (b) Date thereof 4-14-'45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie P. Killian
(b) Address 2 N. Schroeder St

APR 13 1945

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11- 1945, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Vascular Renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

G27850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Haw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Nichols

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1917

8. AGE: Years 28 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Nichols
13. Birthplace Centerville, Md.

MOTHER
14. Maiden Name Cora N. Kiah
15. Birthplace Delaware

16 (a) Informant Cora Nichols Kiah
(b) Address 634 Haw St.

17 (a) Burial (b) Date thereof 4-13-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie P. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)

APR 19 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1945, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945, to 4/10 1945, and that I last saw him alive on 4/10 1945.

Immediate cause of death Respiratory failure — Duration

Due to Bronchiogenic Carcinoma — 3 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D. Chapman, M.D.

Address University Hospital Date signed 4/11/45

G27851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G27851

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6300 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6300 York Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Seitz

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: James M. Seitz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 27, 1866
8. AGE: Years 79 | Months 2 | Days 17 | If less than one day hr. min.
9. Birthplace Harford County, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business --

FATHER
12. Name Henry Hesa
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Glenzer
15. Birthplace Germany

16 (a) Informant James E. Poehlman
(b) Address 2837 Hillen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14th (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location

18 (a) Funeral director E. I. Fanning and Son
(b) Address 1938 E. Lafayette Avenue

APR 13 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 6.35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1939, to April 11 1945, and that I last saw h.. alive on Jan. 24 1945

Immediate cause of death: Carcinoma of Stomach — Duration: 1 year

Due to

Due to

Other Conditions: Metastases to lungs + spine.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Chalfant M.D.

Address 6210 York Rd. Date signed April 13 1945

X

G27852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83a

G27852 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 N Patonnas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N Patonnas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bloom Kwiatkowski Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~: Married

6 (b) Name of husband or wife: Rosaline M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1898

8. AGE: Years 47 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Kwiatkowski
13. Birthplace Poland

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace Poland

16 (a) Informant Rosaline M. Bloom
(b) Address 515 N Patonnas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John C Hogan
(b) Address 3000 E Baltimore St

19 (a) Date received by Local Registrar APR 15 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1945 to April 11 1945 and that I last saw ~~him~~ her alive on April 11 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Cerebral Arteriosclerosis + Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry J Douglas M. D.
Address 100 E. Pratt Date signed 4/17/45

G27853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27853 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 Wall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Wall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irene O'Melia

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. O'Melia

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 8-1891

8. AGE: Years	Months	Days	If less than one day
54	9	3	....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Christopher Ott
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Bailey
15. Birthplace Baltimore Md.

16 (a) Informant Wm. O'Melia
(b) Address 1232 Wall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14-45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Elizabeth Hark Inc.
(b) Address 115 E. West St.

19 (a) ....(Date rec'd by registrar) (b) Huntington Williams Registrar

APR 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to April 11 1945, and that I last saw h[illegible] alive on April 11 1945.

Immediate cause of death: Cerebral hemorrhage

Due to

Due to

Other Conditions Arteriosclerosis Hypertension & Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Coleman
Address 1337 S. Charles St. Date signed 4/13/45 M.D.

X

G27854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

G27854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 "T"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 Gorsuch Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen A. Fagan

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Betty L. Fagan
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1922

8. AGE: Years	Months	Days	If less than one day
22	5	11	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Oculist
11. Industry or business Own City Oculist

FATHER
12. Name John O. Fagan
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Catherine M. Freshfine
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Betty L. Fagan
(b) Address 1637 Gorsuch Avenue

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)
(c) Cemetery or crematory New Catholic Cem
Location 4300 Old Frederick Road

18 (a) Funeral director Elmer H. Conklin & Son
(b) Address 924 E. Eager Street

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Pa

APR 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 45 19, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound Fracture of Ribs & Hemothorax, Rupture of Spleen.

Due to

Other Conditions History of Epilepsy.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 5-1

(a) Date of injury 4-7-45 at 3:05 P.M.
(b) Where did injury occur? Aisquith & Orleans Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Crushed between bus & curbstone

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 12, 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. 627855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Roslyn Ave. & Alto Road
(c) Hospital or institution: Orrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2½ Mos.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Balto. Co.
(c) City or town: Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No.: Harford Road (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: NO

3 (a) FULL NAME: Margaret R. Amy

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife: Ernest C. Amy
6 (c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): April 10, 1865

8. AGE: Years	Months	Days	If less than one day
80	0	1	....hr. ....min.

9. Birthplace: Ontario, Canada (Town, county, and state)
10. Usual Occupation: NONE
11. Industry or business: NONE

FATHER
12. Name: Hugh MacKenzie
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Jessie Russell
15. Birthplace: Scotland

16 (a) Informant: Miss Daisey Marshall
(b) Address: Union Memorial Hospital, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/1945 (month) (day) (year)
(c) Cemetery or crematory: Presbyterian Churchyard
Location: Franklinville, Maryland.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 E. North Av. (W. F. Wooden-Suc.)

19 (a) APR 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 — 11 1945; at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to Apl 11 1945, and that I last saw h[illegible] alive on Apl 10 - 1945.

Immediate cause of death: Carcinoma of larynx — Duration: 9 Mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Howard F. Warren M. D.
Address: 2004 Garrison Blvd. Date signed 4-12-45

VS 180

X

G27856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G27856

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1258 Carroll St.
(c) Hospital or institution: at home 21 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto city
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1258 Carroll
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Cora Willetta Magee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Thos A. Mayne

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 20 1874

8. AGE: Years 71 | Months 32 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Poughkeepsie N.Y.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name James Shirter

FATHER 13. Birthplace Could not ascertain

MOTHER 14. Maiden Name Debora Thicle

MOTHER 15. Birthplace Could not ascertain

16 (a) Informant Maj Todd Friend

(b) Address Salvation Army Balto

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-14-45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore

18 (a) Funeral director Sievers & Mayo Co.

(b) Address 108 W Fayette

19 APR 14 1945 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1945, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1940 to April 12 1945, and that I last saw him alive on 4-11 1945.

Immediate cause of death	Duration
Generalized arteriosclerosis	1 yr.
Due to Probable coronary occlusion	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Thos B. Schaefer M. D.

Address 541 Fulton Ave Date signed 4-13-45

G27857 ✓ G27857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3303 Hayward Ave St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Elsa Alice McMahon

If U. S. Veteran (Specify WAR)

(a) Residence: No. 3303 Hayward Ave St. 27-17 Ward.
(Usual place of abode) (If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas McMahon

6. DATE OF BIRTH (month, day, year) 5/17/1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

FATHER

13. NAME Geo Rodenhyser

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Emma Spedler

16. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

17. INFORMANT Thomas McMahon (Address) 3303 Hayward Ave

18. BURIAL, CREMATION, OR REMOVAL Place Baltimore Date 4-14 1945

19. UNDERTAKER Lorman Byers (Address) 3005 Pk Heights Ave

20. FILED APR 14 1945 Huntington Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4-11, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1945, to April 11, 1945

I last saw her alive on April 11, 1945 Death is said to have occurred on the date stated above, at 4:30a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Apr 44
Coma	5 Days

Other contributory causes of importance:

Arteriosclerosis

Was an operation performed? no Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19—

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify —

(Signed) Edwin J Mell M. D.

(Address) 3276 Park Heights Ave

VS 3

G27858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G27858 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamptuet ave
(c) Hospital or institution: Fewridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 E. Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie C. Ellis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Theo. H. Ellis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 22. 1861

8. AGE: Years 83 | Months 9 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace Worcester County (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William Ellis
13. Birthplace Worcester County

MOTHER
14. Maiden Name Mary E. Puttyer
15. Birthplace Worcester County

16 (a) Informant Clemmye L. Cliff
(b) Address 2622 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16/45 (month) (day) (year)

(c) Cemetery or crematory Mathodist Cemetery
Location Snow Hill Md.

18 (a) Funeral director John Mitchell Towe
(b) Address 1405 Eutaw Place

19 (Date rec'd by registrar) APR 14 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1945 to April 13 1945 and that I last saw her alive on April 11 1945

Immediate cause of death: Chronic myocarditis — Duration

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions: Hypertrophic arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harlow M.D.
Address 4706 Harford Rd. Date signed 4/13/45

VS 150

G27859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G27859

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L. Machen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mattie Machen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3. 1865

8. AGE: Years 80 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mattie Machen
(b) Address 116 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Rd.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 APR 14 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1942, to April 12 1945, and that I last saw h[illegible] alive on April 7 1945.

	Duration
Immediate cause of death: Coronary occlusion	Minutes
Due to:	
Due to: Uremia - selerotic kidneys	
Due to: Organic effort	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M.D. M. D.
Address 3321 Fred Ave Date signed 4-12-45

VS 150

G27860

FL - 91718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. G27860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 19
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Gabriel Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1866

8. AGE: Years	Months	Days	If less than one day
79	0	2	hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Luke Maddox
13. Birthplace Ala.

MOTHER
14. Maiden Name Susanna Brown
15. Birthplace Ga.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date received by registrar APR 14 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1945, at 8pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1945 to Apr. 10 1945, and that I last saw him alive on April 10 1945.

Immediate cause of death	Duration
(a) Bronchopneumonia	24 hrs
Anemia	5 days
Due to Carcinoma of Prostate	8 mos?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-31-45

Major findings of operation: Acute retention - Large nodular prostate

of autopsy: Bronchopneumonia advanced

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Perry M.D.
M. D.
Address 1 Baltimore City Hosps Date signed 4-12-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 E. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1870

8. AGE: Years 74 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Caroline Carter
15. Birthplace Va.

16 (a) Informant Mrs. Ozella Gantt
(b) Address 403 E. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem
Location A. A. Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Filed in registrar's office APR 14 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1945 to 4/13 1945, and that I last saw her alive on 4/12 1945.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Woodland,
Address Provident Hospital Date signed 4/15/45

G27862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G27862

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 W. Lanvale
(c) Hospital or institution:
16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August F. Reinle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1885

8. AGE: Years 59 | Months 7 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Herman J. Reinle
13. Birthplace Switzerland

MOTHER
14. Maiden Name Annie Myers
15. Birthplace U. S.

16 (a) Informant Mrs. Bertha Daum
(b) Address 2419 W. Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Dennybacker
(b) Address 715 Light St.

APR 14 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from ← 19← to ← 19←; and that I last saw h[im] alive on April 11 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arterial Tension

Due to Arterial Sclerosis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard S. French
Address 2329 Arunah Ave. Date signed 4/17/45

VS 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G27863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G27863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret P. Aitken Esty

3 (b) If veteran, name war —

3 (c) Social Security Account No. 231-09-2687

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1897

8. AGE: Years 47 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace Portsmouth, Virginia
(Town, county, and state)

10. Usual Occupation Bar-maid

11. Industry or business

FATHER
12. Name James T. Aitken
13. Birthplace Scotland

MOTHER
14. Maiden Name Louisa Cooper
15. Birthplace England

16 (a) Informant Birth Record
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Portsmouth
Location Va

18 (a) Funeral director William Cook Inc
(b) Address 1347 St. Paul St

19 (a) APR 14 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Fraser M.D.
Medical Examiner.
Date signed 4-13-45

VS 151

G27864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27864

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Henderson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married,~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Anna Henderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 2nd 1880

8. AGE: Years: 64 | Months: 5 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Invalid

11. Industry or business:

FATHER
12. Name: (Unknown) Henderson
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs Irene Henderson
(b) Address: 1732 Ferrell Place

17 (a) Burial: (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery: BALTIMORE CEM ~~Cedar Hill~~
Balto. Md. ~~Arlington Md.~~

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St Paul St

19 APR 14 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1945 to 4/13 1945 and that I last saw h~~im~~ alive on 3/12 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension CVA D	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Willard Applefeld
Address 2511 Pinkerstown Rd Date signed 4/13/45

VS 150

G27865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G27865

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette and Caroline Sts.

(c) Hospital or institution: Franklin Square Hosp. 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 day

(e) Length of stay in Baltimore (yrs., mos., or days) 5 day.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city limits, write RFD, township, or district)

(d) Street No. 1313 W. North Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Clifford Austin Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. — NONE

4. Sex M

5. Color or race W.

6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/8/45 5 day.

8. AGE: Years | Months | Days 4 ✱ | If less than one day hr. min.

9. Birthplace Franklin Balto Md. (Town, county, and state)

10. Usual Occupation New born.

11. Industry or business

FATHER 12. Name Clifford Austin

13. Birthplace Fureches, N. C.

MOTHER 14. Maiden Name Julia Mary Shroder

15. Birthplace York County Pa.

16 (a) Informant Mother - Julia Austin

(b) Address 1313 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt Olivet

Location Balto. Md.

18 (a) Funeral director Williams Cook Inc

(b) Address 1217 St Paul St

19 (a) APR 14 1945 Delivered by registrar Huntington Williams Burial, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1945 to April 12 1945 and that I last saw him alive on April 12 1945

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Coral Gordon M. D.

Address 2201 W. North Ave Date signed 4-12-45

X

627866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G27866

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 N. Patterson Pk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob J. Krummeck

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sennora Krummeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1881

8. AGE: Years 63 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Mail carrier
11. Industry or business U.S. Mails

FATHER
12. Name Charles Krummeck
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Sennora Krummeck
(b) Address 428 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

19 (a) APR 11 1945 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1944 to April 11 45 and that I last saw him alive on April 11 1945

Immediate cause of death: Carcinoma of right lung & general metastases. — Duration: 4 Mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Jungewald M. D.
Address 1613 E. North Ave Date signed 4-13-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G27862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 R Hollins Ferry Rd (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME George Thompson, Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-26-45

8. AGE: Years	Months	Days	If less than one day
		6	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Geo. Thompson, Sr
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Laura Russell
15. Birthplace St. Marys Co. Md.

16 (a) Informant Laura Russell
(b) Address 300 R Hollins Ferry Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Wm Cook, Inc
(b) Address 1617 St Paul St

19 APR 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945 at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	Duration
Dehydration	
Due to 1 Cerebral hemorrhage	
Due to 2 Hemorrhagic disease of newborn	
Other conditions (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation.....
Was autopsy? Yes
Was tissue examined? .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature John R. Birmingham M. D.
Address JHH Date 4/14/45

VS 180

G27858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

Registered No. 3678

G27858

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Harlem Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Simpson

3 (b) If veteran, name war: World War No I
3 (c) Social Security Account No. 214-22-9175

4. Sex: Male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elenora Simpson
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 7 1895

8. AGE: Years 49 | Months 9 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Chester S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business American Shipbuilding Co

FATHER
12. Name Abraham Simpson
13. Birthplace Chester S.C.

MOTHER
14. Maiden Name Mary Lee Cornwell
15. Birthplace Chester S.C.

16 (a) Informant Mrs Elnora Simpson
(b) Address 1602 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-45 (month) (day) (year)

(c) Cemetery or crematory Odd Fyors
Location Chester S.C.

18 (a) Funeral director Sam'l H. Chase Wm
(b) Address 638 W. Fulton St

APR 14 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-1945, at 2.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1945, to 4-12-1945, and that I last saw him alive on 4-12-1945.

Immediate cause of death	Duration
Cerebral hemorrhage	11 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders, M. D.
Address 1029 N. Strieker Date signed 4-13-45

VS 150

X

G27869 QURSUHART ✓ G27869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 W Cross
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 1
(e) Length of stay in Baltimore (yrs.) mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W Cross
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Augustus Qurguhart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 Months Days If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation L

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Nancy ?
15. Birthplace Unknown

16 (a) Informant Clarence Augustus Qurguhart
(b) Address 202 W Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Monument St

19 (a) Date received by Local Registrar APR 14 1945 (b) Thurston for Williamsville, Md. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 2:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 8 1945, to April 12 1945, and that I last saw him alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 M

Due to: Hypertension

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James C Clifton M. D.
Address 1016 E Shaw St Date signed 4-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 N.Kenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N.Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma K.Walker

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Chas.T.Walker
6 (c) If alive, give ~~age~~ ~~1875~~

7. Birth date of deceased (mo., day, yr.) Jan. ~~12/1874~~

8. AGE: Years ~~71~~ 70 | Months 3 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Bennett
13. Birthplace Va.

MOTHER
14. Maiden Name Laura --
15. Birthplace Va.

16 (a) Informant Mrs.Margie Neal
(b) Address 709 N.Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr.16/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Hennigsons
(b) Address 2024 Orleans St.

19 APR 14 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12/45 19... at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to April 12 1945 and that I last saw her alive on April 12 1945.

Immediate cause of death: Cerebral Hemorrhage (Rt. Side - Hemiplegia)
Duration: 4/10/45
Due to arterio-Sclerosis & Hypertension
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis T. Krummen M. D.
Address 732 N. Kenwood Date signed 4/14/45

VS 190

(OVER)

G27871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G27871 Registered No. 3698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 162 W. Lanvale St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 162 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Crawford Gordon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1903

8. AGE: Years	Months	Days	If less than one day
41	5		hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Day worker

FATHER 12. Name Willie Brooks
13. Birthplace Md
MOTHER 14. Maiden Name Lizzie Penn
15. Birthplace Md

16 (a) Informant Bessie Jenwick
(b) Address 162 Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

19 (a) APR 14 1945 (Date rec'd by reg.) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-1945, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1945 to 4-12-1945 and that I last saw her alive on 4-11-1945.

Immediate cause of death	Duration
Carcinoma of Lungs	Unknown
Due to Carcinoma of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 4-14-45

VS 150

G27872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27872

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2409 Oswego Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Oswego Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETTA Z. HORNER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Anderson F. Horner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/20/1870

8. AGE: Years 74 | Months 5 | Days 22,+ | If less than one day ... hr. ... min.

9. Birthplace: Trenton, N. J.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Levi Furhman
13. Birthplace: N. J.

MOTHER
14. Maiden Name: Catherine [illegible]
15. Birthplace: N. J.

16 (a) Informant: Mrs. John A. Young
(b) Address: 2409 Oswego Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19 (a) APR 14 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13, 1945, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1944 to 4-13-1945 and that I last saw h[illegible] alive on 4-13-1945.

	Duration
Immediate cause of death Coronary Thrombosis + Occlusion	1wk.
Due to General Arterio Sclerosis.	Yrs
Due to	
Other Conditions Chronic Bronchitis Hypostatic Pneumonia (Include pregnancy within 3 months of death)	5 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James S Ashcraft M. D.
Address 4012 Park Heights Ave. Date signed 4-14-45

G27873 ✓ G27873

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully collected and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNIE D. HARMAN

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Fred W. Harman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years: 75 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Charwoman-Retired 4 yrs.

11. Industry or business: New Amstardam Casualty Co.

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. Wm. G. Speed, Jr.
(b) Address: New Amsterdam Casualty Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

APR 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945, at 7 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1944 to April 13 1945, and that I last saw her alive on April 6 1945.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: M. H. Patterson M. D.
Address 2324 Reisterstown Rd Date signed 4/14/45

X

G27874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G27874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. Bond Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JOSHUA WRIGHT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE:	Years	Months	Days	If less than one day
	24			hr. min.

9. Birthplace Florala, Ala.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Geo. W. Wright
13. Birthplace Ala.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Geo. W. Wright
(b) Address Florala Ala.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) APR 14 1945 Waiting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945, at 6:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wounds of Head and Neck

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-4-45 at 3 A. M.
(b) Where did injury occur? 124 S Bond ST
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Shot

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed April 4 1945

VS 151

27875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 27875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Maryvarty Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7515 Belmont ave.
(If rural give location)
Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Staver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William Staver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15th 1889

8. AGE: Years 56 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Albert G. Hoffmeister
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Margaret Steer
15. Birthplace Baltimore Co. Maryland

16 (a) Informant Mrs Charles Jones
(b) Address 7515 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16th 1945 (month) (day) (year)

(c) Cemetery or crematory Zion Lutheran
Location Hennyba Run, Md.

18 (a) Funeral director Cassatt Funeral Home
(b) Address 7401 Belair Road

19 (a) APR 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1945 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 4/12 1945 and that I last saw her alive on 4/12 1945

Immediate cause of death Pulmonary embolism, site of thrombosis unfortunate

Duration

Due to Cardiac failure auricular fibrillation

Due to Prostatic heart disease

Other Conditions Cystitis, acute

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto R. Ewing M.D.
Address Union Hosp. Date signed 4/13/45

X

27876 ✓ 27876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

927

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Gilmor St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Selma Jane Ford

If U.S. Veteran specify WAR

(a) Residence: No. 228 N. Gilmor St., 19-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Kent County, Md.

FATHER

13. NAME

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Elizabeth Cotton

16. BIRTHPLACE (city or town) (State or country) Kent County, Md.

17. INFORMANT Eleanor Block.
(Address) 228 N. Gilmor St.

18. BURIAL, CREMATION, OR REMOVAL
Place Chestertown, Md. Date 4-10-1945

19. UNDERTAKER McKaster R. Williams
(Address) 322 E. Pennsylvania Ave. Huntingdon, Williamsport, Md.

20. FILED APR 14 1945
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 10, 1945

22. I HEREBY CERTIFY, That I attended deceased from March 27, 1945 to April 9, 1945

I last saw her alive on April 9, 1945. Death is said to have occurred on the date stated above, at 2:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Myocarditis	Days ill

Other contributory causes of importance:
Chronic Endocarditis
Senility

Was an operation performed? Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No

(Signed) H. T. Loomis M. D.

(Address) 401 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

X

G27877
AB-92975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G27877
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Price Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5- 1886

8. AGE: Years	Months	Days	If less than one day
59	3	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Price Harris (D)
13. Birthplace ?

MOTHER
14. Maiden Name Rosena Edwards(D)
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Recor
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4- 14-'45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Wallgren
(b) Address 3225 N. Schroeder St

19 APR 14 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 10.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1945, to 4-9- 1945, and that I last saw h im alive on 4-9- 1945

Immediate cause of death	Duration
Pulmonary tuberculosis	
Due to Pulmonary tuberculosis	(7)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address Baltimore Maryland Date signed 4/12/45

X

G27878 ✓ G27878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Gladys Barnett

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Moses Barnett

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 1916

8. AGE: Years	Months	Days	If less than one day
28	7		..... hr. ..... min.

9. Birthplace Farmville, N. C.
(Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business .....

FATHER
12. Name Jarvis Tyson
13. Birthplace N. C.

MOTHER
14. Maiden Name Zula Joyner
15. Birthplace N. C.

16 (a) Informant Mrs. Jacob Rhodes
(b) Address 403 N Pearl St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-14-45 (month) (day) (year)
(c) Cemetery or crematory Farmville, N.C.
Location .....

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 APR 14 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 45 19 ..., at 12.55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Miliary Tuberculosis

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
Means of injury .....

Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 12, 1945.

27879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120a

2117 Belair Road

Registered No. C27879

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 E. Monument Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Mary Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widow

6 (b) Name of husband or wife Winfield Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 20 1859

8. AGE: Years	Months	Days	If less than one day
85	9	13	hr. min.

9. Birthplace Calvert County, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Grierson
13. Birthplace Calvert County, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Orille W. Stevens
(b) Address 3016 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-1945 (month) (day) (year)
(c) Cemetery or crematory St Paul's
Location Prince Frederick, Calvert County

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 3018 E. Monument Street

19 APR 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V8 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7- 1945, to 4-13- 1945, and that I last saw her alive on 4-11- 1945

Immediate cause of death	Duration
Chronic Enteritis	9 wks
Due to Diverticulosis of the Colon	?
Due to	
Other Conditions Generalised arterio Solerosis & Senility (Include pregnancy within 3 months of death)	?

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Haag M. D.
Address 2117 Belair Rd Date signed 4-14-45

G27880 ✓ G27880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Cutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4427 Pall Mall Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months Lit | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Phil
13. Birthplace Lith

MOTHER
14. Maiden Name Mamuky
15. Birthplace Lith

16 (a) Informant Hospt Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-14-45 (month) (day) (year)
(c) Cemetery or crematory Phil. Pa.
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

R 4-15-1945 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13- 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9/ 1945 to 4/13/ 1945 and that I last saw h[illegible] alive on 4/13/ 1945

Immediate cause of death: Ruptured gall bladder

Due to: Chole Lithiasis

Due to:

Other Conditions: Myocarditis Arteriosclerosis Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration: about 12 hrs.

Some Yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore H. Morrison M. D.

Address 11 E. Chase St. Date signed 4/15/45

126

G27881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G27881 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk - Baltimore - 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7302 Dunman Way
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ronald Knott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-26-43

8. AGE: Years 0 | Months 11 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Millersburg W. Va.
(town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Charles Raleigh Knott
13. Birthplace West Virginia

MOTHER
14. Maiden Name Virginia Runion
15. Birthplace Virginia

16 (a) Informant Father Chas. R. Knott
(b) Address 7302 Dunman Way - Dundalk

17 (a) Removal (b) Date thereof 4/14/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Charleston
Location West Virginia

18 (a) Funeral director Wm. H. Eichner & Sons
(b) Address Baltimore, Md.

19 (a) ____ (b) ____
(Date rec'd by registrar) Washington Williams, M Registrar

APR 15 1945

5 1945 vs 107

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1945 at 3:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 M 4-14 1945 to 3 P.M. 4-14 1945, and that I last saw him alive on 4-14 1945

Immediate cause of death Bronchopneumonia — Duration

Due to Sepsis

Due to

Other Conditions Marasmus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Bronchopneumonia (early)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Lankford M. D.
Address Church Home & Hosp. Date signed 4-14-45

G27882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G27882 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maria A. Zito

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Giuseppe Zito

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9th 1875

8. AGE: Years 70 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Inatillaro
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Cannagio
15. Birthplace Italy

16 (a) Informant Joseph Zito
(b) Address Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St

19 (a) Date received (b) Registrar

APR 15 1945

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 10 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 24 1945 to Apl 12 1945, and that I last saw h[er] alive on Apl 12 1945.

Immediate cause of death: Chronic General Arteriosclerosis — Duration: Many Years

Due to

Due to

Other Conditions: Chr. Arthritis Deformans & Chr. Myocarditis. — Many Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. W. Keown.

Address 1908 Linden Ave Date signed 4/13/45 M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G27883 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Joseph's Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give
(d) Street No. 1319 Winchester Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country U.S.A.

3 (a) FULL NAME Mrs. Janet Frances

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Norman Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/28/04

8. AGE: Years 44 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace St Mary's County, Md.
(town, county, and state)

10. Usual Occupation Wife.

11. Industry or business

FATHER
12. Name Frank Taylor.
13. Birthplace St Mary's Co.

MOTHER
14. Maiden Name Gloria Milburn
15. Birthplace St Marys Co.

16 (a) Informant Norman Francis
(b) Address 1319 Winchester St

17 (a) Burial (b) Date thereof 4-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location St Mary's Co

18 (a) Funeral director Mrs Frances A Hayden
Address 578 N Bridge St.

19 (a) APR 13 1945 Williamsport, Md.
(Date rec'd by reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1945 to 4/14 1945, and that I last saw h[illegible] alive on 4/14 1945.

Immediate cause of death	Duration
1. Cerebral edema	
2. Cerebral carcinoma	
Due to Secondary Shock.	
Due to	
Other Conditions Fibroid uterus Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation Syphilis

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan E. Cheek M. D.
Address St Joseph's Hosp Date signed 4/14/45

83a

G27884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G27884 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3156 Stafford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3156 Stafford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence V. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ernest E. Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Evelyn E. Burns
(b) Address 3156 Stafford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreaux
(b) Address 1003 W. Baltimore St.

19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar

APR 16 1945
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945, at 3.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to April 13 1945, and that I last saw her alive on April 12 1945

Immediate cause of death	Duration
Cardiac fibrillation	
Due to Lobar pneumonia	10 days
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard S. French, M. D.
Address 2329 Arunah Ave. Date signed 4/14/45

G27885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G27885

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Park Heights Ave

(c) Hospital or institution: Sinai Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2041 Wilkens Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME HANNAH SNYDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife MORRIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 89 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name LAIB TAVAN

13. Birthplace RUSSIA

MOTHER 14. Maiden Name MIRIAM

15. Birthplace RUSSIA

16 (a) Informant MAMIE SNYDER

(b) Address 2041 WILKENS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-15-45 (month) (day) (year)

(c) Cemetery or crematory HERRING RUN

Location Phila Rd + Bowleys Lane

18 (a) Funeral director Jos. Sayers Inc.

(b) Address 1439 E. Balto St

19 (a) Filed by registrar Williams MD Registrar

(b) APR 15 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-45 19 at 2.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 19 45 to 4/13 19 45 and that I last saw h[illegible] alive on 4/13/45 19

Immediate cause of death: acute cardiac failure — Duration

Due to Ch Coronary Sclerosis

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. L. Hornstein M. D.

Address 733 Argyle St Date signed 4/14/45

X

G27836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27836

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2020 3401 Leary Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nathan Waxman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Manuel

13. Birthplace Poland

MOTHER 14. Maiden Name Bertha

15. Birthplace Poland

16 (a) Informant Hospt Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Md

Location Windsor Mill Md

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 Baltimore Huntington Ave Baltimore, Md

(c) (Date rec'd by registrar) APR 15 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1945 to April 15 1945 and that I last saw h. alive on April 15 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Hypertension & Arteriosclerotic Heart Disease	
Due to	
Other Conditions Azotemia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Brown M.D.

Address Sinai Hospital Date signed 4/15/45

G27837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G27837

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits write RURAL and give town)

(d) Street No. 17 N. Ann St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME WILLIAM PLEET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fanny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

MOTHER | FATHER

12. Name Sam

13. Birthplace Russia

14. Maiden Name Fong

15. Birthplace Russia

16 (a) Informant Hoyt Rieach

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-45 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Park Ave Baltimore Co

18 (a) Funeral director Jos L Lewis Sons

(b) Address 1439 E. Baltoff

APR 5 1945 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945 at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1945 to 4/14 1945, and that I last saw h/M alive on 4/14 1945

Immediate cause of death Cardio Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to Hypertensive C-V disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J Sumner

Address Sinai Hospital Date signed 4/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G27888 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1642 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 E Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Ebenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	married

6 (b) Name of husband or wife Marcus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Metchel
13. Birthplace Poland

MOTHER
14. Maiden Name Pearl
15. Birthplace Poland

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 4-14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Pike & Kenwood Ave

18 (a) Funeral director Jos. L. Lewis Son
(b) Address 1439 E. Balto St

19 (a) (b) Registrar
(Date rec'd by registrar)

APR 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-45 19 , at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 , to 4-14 19 45 ; and that I last saw her alive on 4/13 19 45 .

Immediate cause of death Coronary occlusion — Duration ?

Due to

Due to

Other Conditions Diabetes mellitus
Bilateral cerebral hemorrhages — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 2904 Rent Rd Date signed 4/13/45

9da

G27889

BALTIMORE CITY HEALTH DEPARTMENT ✓ G27889

CERTIFICATE OF DEATH 45B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Weitzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 1-14-1879

8. AGE: Years 66 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Weitzman

13. Birthplace ?

MOTHER 14. Maiden Name Rebecca ?

15. Birthplace

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Hill Mem. Park

Location Windsor Mill Rd. Baltimore

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balt St.

19 (a) APR 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to April 13 1945 and that I last saw him alive on April 13 1945.

Immediate cause of death CORONARY OCCLUSION — Duration 4 Minutes

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Carcinoma of Tongue — Months

(Include pregnancy within 3 months of death)

Date of operation 4/13/45

Major findings of operation: Carcinoma of Tongue

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Woods Jr.

Address Johns Hopkins Hospital Date signed 4/13/45

VS 150

G27890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G27890

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 N. Smallwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N. Smallwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TEMA SMELKINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife MICHAEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name RUBIN COONIN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name LENA
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD & HAMILTON AVE
18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.
19 (a) 4-15-45 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/45 19 , at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 to 4/13 1945 and that I last saw h[illegible] alive on 4/12 1945

Immediate cause of death	Duration
(a) Acute Coronary Occlusion	2 hrs.
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions Contributing (d) Arteriosclerosis	7 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 2904 Rusk Rd Date signed 4/14/45

VS 150

G27891 G27891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5247 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5247 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose G. Franklin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER 12. Name Daniel Hassen
13. Birthplace Ireland

MOTHER 14. Maiden Name Rose G. Hassen
15. Birthplace Ireland

16 (a) Informant Mrs. J. Walter Lee
(b) Address 2700 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore Md

18 (a) Funeral director Maurice Cook Dyer
(b) Address 1600 N. North Ave

19 (a) (b) Huntington Williams M.D. Registrar
Registered by registrar 4/15/45

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1944 to 4/13 1945, and that I last saw h alive on 12/12 1944

Immediate cause of death Cardiac Failure — Duration

Due to Degenerative cardio-vascular disease

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Wilson M. D.
Address 5721 Park Heights Ave Date signed 4/13/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 27B

G27892
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Maryland Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Mt. Ambrose ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph O. Norfolk

3 (b) If veteran, name war N/A
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Janice Norfolk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 | 26 | 1909

8. AGE: Years 35 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Steam Crane Operator

11. Industry or business

FATHER
12. Name Richard Norfolk
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Lehanarty
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

(a) Huntington Williams, M.D.
(b)
Registrar

APR 15 1945
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945 at 6 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-44 19 to 4-13-45 19, and that I last saw him alive on 4-13-45

Immediate cause of death Empyema, rt.

	Duration
Due to Liver abscess, with rupture into pleural space	
Due to Amebic Dysentery	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-23-45

Major findings of operation: abdomen abscess

of autopsy: empyema, liver abscess, ulcers of colon

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Brady, M. D.
Address Md. Gen. Hosp Date signed 4-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G27893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5631 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia C. Ziegenheim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Frank Ziegenheim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28 1865

8. AGE: Years 80 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Steininger
13. Birthplace Md.

MOTHER 14. Maiden Name Catherine Of
15. Birthplace German

16 (a) Informant Mrs Jesse Frafein
(b) Address 624 S. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18 1945 (month) (day) (year)
(c) Cemetery or crematory Bal Lawn Mem Park
Location Loyalty Ave

18 (a) Funeral director John F. Griffin
(b) Address 2334 Jefferson St.

APR 15 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-45 19..., at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-45 19..., to 4-11-45 19..., and that I last saw her alive on 4-11-45 19...

Immediate cause of death: cerebral hemorrhage — Duration

Due to: Hypertensive cardiovascular disease

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation 3-29-45

Major findings of operation: diabetic gangrene of foot & knee thigh amputation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Brady M. D.

Address Md. Gen. Hosp. Date signed 4-11-45

Huntington Williams, MD

920

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G27894 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Y. M. C. A. (Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Shoemaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife -----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1873

8. AGE: Years 71 | Months 9 ? | Days 12 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business

FATHER
12. Name William A. Shoemaker
13. Birthplace Pa.

MOTHER
14. Maiden Name Eliza J. Radcliffe
15. Birthplace Pa.

16 (a) Informant Mrs. Mary A. Campbell
(b) Address 29 E. School House Lane, Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cemetery
Location Tamaqua, Pa.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) Date received by registrar APR 16 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1945 at 1.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Apr 14 1945
and that I last saw him alive on Apr 13 1945

Immediate cause of death Bronchial Pneumonia — Duration 2 days

Due to Coronary Occlusion — Duration Since Dec 7/44

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Kuser M. D.
Address Whitewood Apts. Date signed 4-14-46

M. D. R. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G27895 G27895

CERTIFICATE OF DEATH 83 B

1. PLACE OF DEATH House of Good Shepherd 1924

CITY OF BALTIMORE: (No. 15 S. Mount St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Sister Mary of St. Teresa (Alice McCabe)

(a) Residence: No. 15 S. Mount St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 12 1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
81	81	4		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Invalid

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

FATHER

13. NAME John J. McCabe

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Ann M. Bradley

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Sisters of the Good Shepherd
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Cathedral Date 4/16/45 19

19. UNDERTAKER D. J. Foley & Sons
(Address) 1629 Light St.

20. FILED APR 15 1945 19 Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 14th, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1945 to April 14th, 1945

That saw h[illegible] alive on April 13th, 1945. Death is said to have occurred on the date stated above, at 8 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Thrombosis (Arterial)	Jan 10th '45
Myocardial Insufficiency	Jan 1924

Other contributory causes of importance:

Arteriosclerosis	many years
Hypertension	—

Name of operation — Date of —

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) [signature] M. D.

(Address) 1300 Eutaw St.

X [signature]

G27896 G27896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. Potomac St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Basignani

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-09-9428

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21/80

8. AGE: Years 64 | Months 5 | Days 22 | If less than one day: hr. min.

9. Birthplace Italy (City, county, and state)

10. Usual Occupation Stonemason

11. Industry or business

FATHER
12. Name Lorenzo Basignani
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Babucci
15. Birthplace Italy

16 (a) Informant Agnese Basignani (Wife)
(b) Address 701 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) Date received by local registrar APR 13 1945 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/45 19 , at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1945 to 4/13 1945, and that I last saw h[illegible] alive on 4/13 1945

Immediate cause of death: Renal Toxemia

Due to: Retention of Urine

Due to: Enlarged Prostate

Other Conditions: Small Intestine

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Pratt M.D.

Address St. Joseph's Hosp. Date signed 4/14/45

G27897 Carrozza 160C G27897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution: Hospital St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days) day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 S. High St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carrozza
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/14-1945

8. AGE: Years	Months	Days	If less than one day
9 hours			9 hr. 16 min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John N. Carozza
13. Birthplace Italy

MOTHER
14. Maiden Name Elizabeth Felicetti
15. Birthplace Baltimore Md

16 (a) Informant John N. Carozza (Father)
(b) Address 400 S. High St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Wellor Home
(b) Address 52 N. Monroe St

19 (a) (Date) (b) Clayton Williams, M.D. Registrar
(Date) received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1945 to 4-14 1945, and that I last saw h.r. alive on 4-14 1945.

Immediate cause of death	Prematurity		Duration
Due to	Premature Separation of Placenta		
Due to	Birth by Cesarean Section		
Other Conditions			

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Steer
Address St Agnes Hosp. Date signed 4/19/45 M.D.

627898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 627898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 Foster ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Foster ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Th. Brodka

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215 07 2175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fronie Brodka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 26, 1885

8. AGE: Years	Months	Days	If less than one day
59	7	18	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork & Seal

FATHER
12. Name Frank Brodka
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Fronie Brodka (wife)
(b) Address 312, Foster ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 16/45 (month) (day) (year)

(c) Cemetery or crematory HOLY ROSARY
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) APR 1945 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13- 1945, at 2:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 4-13-45

Huntington Hospital

Dr. Marr
516 Cathedral St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33a

Registered No. G27899

7899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Goodwood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Goodwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Grau

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Selma A. Grau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1865

8. AGE: Years 79 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Selma A. Grau
(b) Address 2808 Goodwood Road #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

APR 16 1945 Huntington Williams M.D. Registrar
Date Received Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945, to April 11 1945, and that I last saw h.. alive on April 10 1945.

Immediate cause of death: Pulmonary Edema — Duration 2 hrs
Due to: Cardiac Insufficiency — Duration 2-3 years
Due to: Old Age — Duration 8 days
Other Conditions: Grippe
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Marr M. D.
Address 516 Cathedral Date signed 4-13-45

(OVER) 95-C

VS 150

G27900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G27900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colvert
(c) Hospital or institution: Union Memorial Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City of Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs. George Beaden Kopf) Laura G. Beadenkopf

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George Beadenkopf Dead 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/21/60

8. AGE: Years	Months	Days	If less than one day
84	11	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Luther Meredith Gorsuch
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Henderson
15. Birthplace Maryland

16 (a) Informant Hosp. chart
(b) Address Union Memorial

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16/45 (mo., day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto. Co. Md.

18 (a) Funeral director John J. Mitchell Inc.
(b) Address 900 Eutaw Place

19 (a) APR 16 1945 (b) Thurlington Williams, M.D.
(Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1945, at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1945, to 4-13 1945 and that I last saw her alive on 4-13 1945

Immediate cause of death	Duration
Cardio-resp failure	
Due to Bronchopneumonia, bilateral	
Due to	
Other Conditions Arterio-sclerotic heart disease, cataracts bilateral senile	

(Include pregnancy within 3 months of death)
Date of operation 4-3-45
Major findings of operation: Senile cataracts, bilateral
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Grier M. D.
Address Union Memorial Hosp. Date signed 4-13-45

627901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

627901 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1767 Montpelier St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillian A. Furst

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/83

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	2	8		

9. Birthplace Charleston W. Va. (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business Running house

FATHER
12. Name James A. Engle
13. Birthplace W. Va.

MOTHER
14. Maiden Name Elizabeth Jane Mateer
15. Birthplace W. Va.

16 (a) Informant Mrs. Mary Brandenburg
(b) Address 1767 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 APR 16 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945, at 3 46 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1945 to 4/14 1945, and that I last saw her alive on 4/14 1945.

Immediate cause of death	Duration
Cardiac Failure.	
Due to Generalized Carcinomatosis.	
Due to Biliary obstruction	
Other Conditions Diabetes.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Large Stone in Gall Bladder
of autopsy: General Ca Peritoneal Carcinosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Seaver
Address St. Joseph's Hosp. Date signed 4/17/45 (M. D.)

VS 150

G27902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G27902 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 W. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fauntleroy Maxwell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	married

6 (b) Name of husband or wife John Maxwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace Denton, Md
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name Harrison Bates
13. Birthplace Md

MOTHER 14. Maiden Name Emma —
15. Birthplace Md

16 (a) Informant John Maxwell
(b) Address 340 W. Abbot St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James Astaya
(b) Address 142 W. Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 16 1945

Huntington Hollingsworth, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 15 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15-1945 to 4-15-1945, and that I last saw h.. alive on 4-15-1945.

Immediate cause of death Hypertensive C.V. Disease — Duration ?

Due to

Due to

Other Conditions Uterine Fibroids, ? Dropsy.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See Gross

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Eskelich M. D.
Address 1213 Light St. Date signed 4-15-45

X

G27903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G27903

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Schuck St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Schuck St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Fanslau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1874

8. AGE: Years	Months	Days	If less than one day
70	4	7	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation house wife

11. Industry or business

FATHER
12. Name Paul German
13. Birthplace Germany

MOTHER
14. Maiden Name Anna
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 3305 Schuck St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory 1st Evan. Cemetery
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
Address 1659 N. Broadway

19 (a) APR 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to April 11 1945 and that I last saw h-r alive on April 11 1945.

Immediate cause of death	Duration
Coronary Thrombosis	acute
Due to Coronary Heart Disease	3 mos
Due to Diabetes Mellitus	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Ziegler M. D.
Address 700 W. Lafayette Ave Date signed 4/14/45

627904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 627904

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 S Bouldin ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Gorge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1892

8. AGE: Years 52 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fred. Woolshleger
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lottie Pfiffer
15. Birthplace Baltimore Md.

16 (a) Informant Charlotte Gostomski
(b) Address 1117 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date rec'd by registrar) APR 16 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1945, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1945 to 4-12 1945 and that I last saw h.e.r. alive on 4-12 1945

Immediate cause of death: Cardio-respiratory Failure — Duration

Due to: Cerebral Hemorrhage

Due to: hypertension.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.
Address 27 Gorsuch Ave Date signed 4-12-45

VS 100

G27905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G27905

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 Fleet St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Fleet St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Scheufel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Katherine Maule

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1856

8. AGE: Years 88 | Months 5 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name not known
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Mrs. Amelia Gundlack
(b) Address 3121 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (b) Huntington Williams M.D.

APR 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12- 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8- 1944, to 4-12- 1945, and that I last saw him alive on 4-9- 1945.

Immediate cause of death	Duration
Chronic Myocardial degeneration	9 mos.
Due to Generalised arterio sclerosis	?
Due to Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Shelton C. Lang M. D.
Address 2117 Belair Date signed 4-14-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

627906 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Madison ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbert A Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-6-1888.

8. AGE: Years 56 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace A. A. County Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Brooks.
13. Birthplace Md.

MOTHER 14. Maiden Name Sarah C Gaither.
15. Birthplace Md.

16 (a) Informant Mary E Brooks
(b) Address 1616 Madison ave

17 (a) Burial (b) Date thereof 4-17-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pt. Rest Cemetery
Location A. A. County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) APR 16 1945 Registrar
(Date the day is filed)

VS 150 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to April 13 1945.
and that I last saw him alive on April 13 1945
Immediate cause of death Coronary Thrombosis

Due to

Due to (Hem)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration Chronic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Garland Theriault

Address 1534 Druid Hill Ave Date signed April 14

G27907 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

✓ G27907 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 S. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Dragonuk

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nick Dragonuk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known?

8. AGE: Years About 50 | Months | Days | If less than one day hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace Russian

MOTHER 14. Maiden Name ?

15. Birthplace Russian

16 (a) Informant Nick Dragonuk

(b) Address 111 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-18-45 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian Location Stoney Run, Md

18 (a) Funeral director John A. Gebhardt's Sons

(b) Address 423 S. Paca St

19 (a) APR 16 1945 (Date rec'd by registrar) Hampton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Apr 14 1945, and that I last saw h[er] alive on Apr 14 1945.

Immediate cause of death Carcinoma of lung — Duration 6 mos +

Due to —

Due to —

Other Conditions Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Novak

Address 101 W. Read St Date signed 4-16-45

X

G27908 | 1 | ✓ | G27908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 S. High St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 S. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie or Rosetta E. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Chas. E. Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known?

8. AGE: Years: About 69? | Months | Days | If less than one day: hr. min.

9. Birthplace ? (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? Perry

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant John A. Strebjancka Jr

(b) Address 423 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location O'Donnell St.

18 (a) Funeral director John A. Strebjancka Jr

(b) Address 423 S. Paca St

19 (a) APR 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945, to April 13 1945; and that I last saw h[illegible] alive on April 13 1945.

Immediate cause of death: Valvular heart disease — Duration: 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Silverstein M.D.

Address 2 E. Preston Date signed 4/13/45

VS 150

G27909 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G27909

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH Chas F32nd Ln

CITY OF BALTIMORE: (No. Cambridge Apartment St. N Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..yrs..mos..ds. How long in U. S. If of foreign birth? ..yrs..mos..ds.

2. FULL NAME Grace Howard Campbell V

If U. S. Veteran specify WAR None

(a) Residence: No. Cambridge Apartment St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

THIS IS PERMANENT RECORD. Every item
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS
information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Stuart Campbell

6. DATE OF BIRTH (month, day, year) October 17 1862

7. AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
82	5	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) None

11. Total time (years) spent in this occupation None

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

FATHER

13. NAME George J. Appold

14. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

MOTHER

15. MAIDEN NAME Sarah Mackenzie

16. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

17. INFORMANT Mrs. Tacy C. Clements (daughter)
(Address) Cambridge Apartment, City.

18. BURIAL, CREMATION, OR REMOVAL
Place Greenmount Cemetery Date 4/16/45 19

19. UNDERTAKER STEWART & MOWEN COMPANY
(Address) (W. F. WOODEN SUC.) 1418 W. NORTH AVENUE

20. FILED Huntington Williams Registrar.

APR 16 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4/14, 1945

22. I HEREBY CERTIFY, That I attended deceased from July 1940 19.. to 4/14 1945

I last saw her alive on 4/14 1945 Death is said to have occurred on the date stated above, at 6 P.M.

The principal cause of death and related causes of importance were as follows:

	Duration of onset
Cerebral hemorrhage	2 days

Other contributory causes of importance:

Arterio sclerosis	Many
Myocarditis	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury ..., 19..

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) W H Mosley, M. D.

(Address) 140 W Park Ave

X

Dr. Frankenstein
4322 Ft. Paul St
7910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 627910

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 W 38th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 W 38th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Stanley Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Minnie E. Jones
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1889

8. AGE: Years	Months	Days	If less than one day
55	3	17	hr. min.

9. Birthplace Maryland. (Town, county, or state)
10. Usual Occupation Meat Cutter
11. Industry or business John H. Hampshire

FATHER
12. Name Wm. A. Jones
13. Birthplace Maryland.

MOTHER
14. Maiden Name Flora Talp.
15. Birthplace Maryland.

16 (a) Informant Minnie E Jones.
(b) Address 1104 W 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16 1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampstead

18 (a) Funeral director Kenneth R. Sinnott
(b) Address 3615-17 Christopher

19 APR 16 1945 (b) Hunter for Williamson, M.D.
(Filing date) (By registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945 at 8:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to Myocarditis	
Due to Cachexia	
Other Conditions Abr. Bronchitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 1238 Wash St Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

627911

Registered No. 120159

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Keaton & Wilkens

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1545 N. Payson st (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Bertha Codner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Reuben

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 3, 1913

8. AGE: Years 32 | Months 2 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER 12. Name Robert Block

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Rose Zusnuowitz

MOTHER 15. Birthplace Russia

16 (a) Informant Reuben Codner

(b) Address 1545 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, (month) (day) (year)

(c) Cemetery or crematory Emai Israel Cemetery

Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) (Date Rec'd by Registrar) (b) Huntington Williams M.D. Registrar

APR 16 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1945, at 545 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1944 to 11/19 1945 and that I last saw her alive on 4-15 1945

Immediate cause of death Heart failure — Duration

Metastatic carcinoma

Due to carcinoma of breast

Due to

Other Conditions pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation 10/30/44 11/4/44

Major findings of operation: ovarian tumor

Ca of breast

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

1945 (b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard W Stier

Address St agnes Hosp Date signed 4/15/45

X

G27912

BALTIMORE CITY HEALTH DEPARTMENT

CWK-93121

CERTIFICATE OF DEATH 1496

Registered No. G27912

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 17- 6-- 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monica Burns Blair

S23300

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter Blair
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1927

8. AGE: Years	Months	Days	If less than one day
17	6	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John J. Burns,
13. Birthplace Baltimore-Md.

MOTHER
14. Maiden Name Florence White
15. Birthplace N. Y.

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Johnnycake
Location Catonsville Md.

18 (a) Funeral director William Clark Jr.
(b) Address 617 E. Lexington St.

19 APR 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 14 1945, at 6:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1945, to April 14 1945, and that I last saw her alive on April 14 1945

Immediate cause of death: Massive Atelectasis — Duration ?

Due to

Due to

Other Conditions Pregnancy, delivered at term
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Same as Hist. Changes in Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Burns, Jr. M.D. M. D.

Address Balto City Hosp Date signed 4/15/45

To be approved by the Medical Examiner Howard J. Malloy M.D.

627913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

Registered No. 627913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank L. Reinsfelder

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband~~ wife: Anna Reinsfelder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 22nd 1862

8. AGE: Years: 82 | Months: 3 | Days: 11 2/2 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Gas & Electric Co.

FATHER
12. Name: John Reinsfelder
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara (Unknown)
15. Birthplace: Germany

16 (a) Informant: Joseph P. Reinsfelder
(b) Address: 2032 E. Lanvale St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/17/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

19 (a) 1945 (Date rec'd by registrar) (b) Hunting Town, Millville, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, ~~suicide~~ ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subdural Hematoma traumatic

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 8-6 P.
(a) Date of injury April 9, 1945 11 A.M.
(b) Where did injury occur? Federal & Castle Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury: Struck by taxi cab

23. Signature: Robert Lee Knabe M.D. Medical Examiner.
Date signed 4-13-45

627914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 627914

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3905 White Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Amelia Davidson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1873

8. AGE: Years	Months	Days	If less than one day
71	6 5	20 10	hr. min.

9. Birthplace Liverpool, England (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Law office 22 Private school

FATHER
12. Name John H. Davidson
13. Birthplace Belfast, Ireland

MOTHER
14. Maiden Name Jane Devitt
15. Birthplace Ireland

16 (a) Informant Mrs. Leslie Mitzel
(b) Address 3905 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18 45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md
18 (a) Funeral director William Cook Inc
(b) Address 217 E Paul Street
19 (c) APR 16 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15- 1945, at 1 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13- 45 to 4-14- 1945 and that I last saw her alive on 4-14- 1945

Immediate cause of death Cerebral Hemorrhage — Duration 3 dys.
Due to Arteriosclerosis — 20 yrs
Due to
Other Conditions Chronic myocarditis — 10-15 y
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 4-15-45

G27915

CWK-92234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G27915 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 23
(e) Length of stay in Baltimore (yrs., mos., or days) 58- 5- 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 W. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorette Margaret Magill

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25-1886

8. AGE: Years	Months	Days	If less than one day
58	5	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Magill
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Egan
15. Birthplace Ireland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1247 St Paul St

19 (a) APR 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945, 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1945, to April 14 1945, and that I last saw her alive on April 14 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerosis HD	
Due to	
Other Conditions Ca of Stomach c Metastasis	

(Include pregnancy within 3 months of death)

Date of operation 4-13-45
Major findings of operation: As above
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Butler M. D.
Address City Hospitals Date signed 4-17-45

627916 AB-92386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. 627916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos- 11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 S. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Adam Wajer

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-8912

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Lottie Glebe (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10- 1890

8. AGE: Years	Months	Days	If less than one day hr.	min.
55	1	4		

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals(Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4 17 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Blvd
18 (a) Funeral director Martin F. E. Dippel
(b) Address 3345 S. Oldham St.

APR 16 1945
(Date rec'd by registrar)
Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14- 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3- 1945, to 4- 14 1945, and that I last saw h- im alive on 4-14- 1945

Immediate cause of death Cardiac decompensation — Duration 7

Due to arteriosclerotic heart disease. — Duration ?

Due to — Duration

Other Conditions Chronic cystitis Pulmonary emphysema — Duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post.

23. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Baltimore Md. Date signed 4-14-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

9 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G27917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 N. Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N. Parrish St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd Osborn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Mar.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alfred Osborn
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Va.

16 (a) Informant Elizabeth Osborn
(b) Address 818 N. Parrish St.

17 (a) Burial (b) Date thereof 4/16/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave. Huntington Woods, Md.

APR 16 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945 at 5 1/2 P.M.

21. I certify that death occurred on the date above stated at the hour stated from June 1945 to April 15 1945 and that I last saw him alive on April 1 1945

Immediate cause of death: Diabetes Mellitus — Duration 4 Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 4/16/45

VS 150

G27918

BALTIMORE CITY HEALTH DEPARTMENT ✓ 183 G27918 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a 16
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Franklintown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Engel

3 (b) If veteran, name war In the present Service — 3 (c) Social Security Account No. 705-12-5140

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mable R. Engel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1920

8. AGE: Years	Months	Days	If less than one day
25 24	9 2	20 2	hr. min.

9. Birthplace New York, N.Y.
(Town, county, and state)
10. Usual Occupation Carpenter's Mate
11. Industry or business U.S. Maritime Service

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace St. Michael's Md

16 (a) Informant Rev. Benj. H. Pindell
(b) Address 633 Franklintown Rd.

17 (a) ~~Burial~~ (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Baltimore Md

18 (a) Funeral director Charles F. Schwab.
(b) Address 505 N. Monroe St.

APR 16 1945 (Date rec'd by local registrar) Huntington Williams Mgr.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1945 at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-12-45 at 2:45 P. M.
(b) Where did injury occur? Brewerton Channel - Sparrows Pt - Balto Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes.
(d) Means of injury Drowning

23. Signature Howard J. Whitacre M.D.
Medical Examiner.
Date signed 4-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR READING

627919 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 627919

JO #93083

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Dundalk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Mamalis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nicholas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 17 1887

8. AGE: Years	Months	Days	If less than one day
57	8	26	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Pantaloukas
13. Birthplace Greece

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Greece

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-16-45 (month) (day) (year)
(c) Cemetery or crematory Cemetery Location Loraine

18 (a) Funeral director Lambros Fun. Home Inc.
(b) Address 438-446 E. North Ave

19 (a) APR 16 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13, 1945, at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12, 1945, to Apr. 13, 1945, and that I last saw her alive on Apr. 13, 1945.

Immediate cause of death	Duration
Cardiac insufficiency	12 hrs
Due to Myocardial infarction	12 hrs
Due to Arteriosclerotic heart disease	?
Other Conditions Diabetes, Nephritis, Pulmonary infarct from mural thrombus	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 4-13-45

93D

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G27920 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5011 Midwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5011 Midwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMIL LUTHY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-8583

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Ida G. Luthy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	16	hr. min.

9. Birthplace Queens Anne Co., Md. (Town, county, and state)
10. Usual Occupation Estimator
11. Industry or business Interstate Roofing Co.

FATHER
12. Name August F. Luthy
13. Birthplace France

MOTHER
14. Maiden Name Mary M. Lenherr
15. Birthplace Switzerland

16 (a) Informant Mrs. Emil Luthy
(b) Address 5011 Midwood Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Balto., Md.

18 (a) Funeral director Loveless Funeral Home
(b) Address 7401 Belair Road

19 (a) APR 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9/45 to 4/14/45 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis

Due to

Due to Hypertension

Other Conditions Senile Myocarditis

(Include pregnancy within 3 months of death)

Date of operation X

Major findings of operation: X

of autopsy: X

Duration
1 day

Physician(s): Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work? X
(e) Means of injury X

23. Signature W. A. Pearre M. D.
Address 10 E. Eager Date signed 4/14/45

X

627921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

627921 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5440 Bel Air Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5440 Bel Air Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Reinecke

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-5199

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	M

6 (b) Name of husband or wife Mary A. Koppelman
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	21	hr. min.

9. Birthplace Raspeburg, Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Shop foreman
11. Industry or business Sewing machine repairs

FATHER
12. Name Dietrich Reinecke
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Lutz
15. Birthplace Raspeburg, Balto. Co. Md.

16 (a) Informant Mrs. Wm. E. Reinecke
(b) Address 5440 Bel Air Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave.

18 (a) Funeral director Loveless Funeral Home
(b) Address 7401 Belair Rd. Nottingham

19 (a) Filed by [illegible] Registrar for

APR 10 1945

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14- 1945, at 515 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1944 to 4-14- 1945, and that I last saw h im alive on 4-14- 1945

Immediate cause of death	Duration
Cerebral arteriosclerosis	3 yr 8 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A.L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 4-15-4

X

G27922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G27922

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132 E. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 E. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Diggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1884

8. AGE: Years 60 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Elizabeth Marshall
(b) Address 104 East St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Joseph B. Lock Jr
18 (a) Funeral director
(b) Address 138 N. Central Ave

19 (a) D 16 1945 (Date rec'd by registrar) (b) Huntington Nelligan, M.D. Registrar

VE 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945, at 8:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25-45 19, to 4-14-45 19, and that I last saw h X alive on 4-12-45 19

Immediate cause of death	Duration
Hypertension Cardiac Renal Disease	2yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Malvern Adams, M. D.
Address 312 E. 33rd Date signed 4-16-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

627923 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene St

(c) Hospital or institution: University Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 3

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 N. Gilmore St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Fields Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Goldie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1916

8. AGE: Years 28 Months 4 Days 13 If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER

12. Name Robert Fields, Sr

13. Birthplace md

MOTHER

14. Maiden Name Henrietta Boyer

15. Birthplace md

16 (a) Informant Robert Fields, Sr

(b) Address 1024 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. D. Kelson

(b) Address 1303 Pressman

19 (a) 1945 (Filed by registrar) (Huntington Williams Md Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945, at 5:30 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/1 1945 to 4/14 1945, and that I last saw h.m alive on 4/14 1945.

Immediate cause of death Mes F Failure — Duration

Due to Exploratory Laparotomy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/5/45 Exploratory Laparotomy

Major findings of operation: Valvules

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

Means of injury

23. Signature Millard T. Fralick

Address Lawrence & Hoffman Date signed 4/17/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

27924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 60

Registered No. 27924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts.
(c) Hospital or institution:
Bon Secour
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Baltimore~~ Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5706 First Avenue.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Della Agnes Garing Armstrong

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or ~~wife~~ Frank Oliver Armstrong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 15-1882

8. AGE: Years	Months	Days	If less than one day
62	3	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Straw Hat Operator
11. Industry or business Kay Hat Co.,

FATHER
12. Name James H. C. Garing
13. Birthplace Frederick, Maryland

MOTHER
14. Maiden Name Agnes Bond
15. Birthplace Maryland

16 (a) Informant Mr. Frank O. Armstrong
(b) Address 5706 First Ave. Halethorpe, Md.

17 (a) Burial (b) Date thereof April 17-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) APR 16 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23/45 19 , to 4/14/45 19 and that I last saw her alive on 4/14/45 19 4/14/45

	Duration
Immediate cause of death Congestion	
heart failure	2 wks.
Due to carcinoma breast-	3 yr.
b. lateral & metastesis	
Due to to liver	
Other Conditions Diabetes mellitus	5 yr.

(Include pregnancy within 3 months of death)
Date of operation 3/24/45
Major findings of operation: carcinoma breast - bilateral
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grayson S. Waldrop
Address Bon Secours Hospital Date signed M/D 4/16/45

627925 May 10, 1865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 627925

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3925 Ridgewood Ave.
(c) Hospital or institution: 15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3925 Ridgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HERMAN KAHNBERG

3 (b) If veteran, name war: Spanish American World War #1
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 | 10 | 1865

8. AGE: Years	Months	Days	If less than one day
79	11	3	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Retired Chief Boatswain Mate
11. Industry or business U. S. C. G.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Harry C. Craig
(b) Address 3925 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (APR 16 1945) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apl. 8 1945 to Apl 13 1945, and that I last saw him alive on Apl 11 1945

Immediate cause of death Coronary Thrombosis — Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Johnson M. D.
Address 403 Med Arts Bg Date signed 4-16-45

VS 150

627926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 627926

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 Marydell Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Marydell Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. BALDWIN

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ✓ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1864

8. AGE: Years 80 | Months 9 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired (mail carrier)

11. Industry or business

FATHER
12. Name John Badwin
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Smith
15. Birthplace Md.

16 (a) Informant Mrs. Clara Harrington
(b) Address 303 Marydell Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1 Balto., Md.

19 (c) APR 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1945 at 4.45 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to 4/14 1945 and that I last saw him alive on 4/14 1945

Immediate cause of death: Uremia nephritis (interstitial) — Duration: 1 yr

Due to:

Due to:

Other Conditions: acute cystitis — 2 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 203 W. Wilkens Ave. Date signed 4/16/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

527927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 527927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 LAURETTA AVE.
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 LAURETTA AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOPHIA L. HOFFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife OTTO P. HOFFMAN

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) MAY-14-1888

8. AGE: Years 56 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER 12. Name "SEITER"

13. Birthplace GERMANY

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace

16 (a) Informant OTTO P. HOFFMAN

(b) Address 2526 LAURETTA AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location FREDERICK AVE.

18 (a) Funeral director CHESTER WEBER

(b) Address 2303 EDMONDSON AVE.

19 (a) APR 16 1945 (b) Huntington Williams, M.D. (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, 3:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw ~~him~~ her alive on Jan 1944

Immediate cause of death: Coronary occlusion — Duration —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells. M. D.

Address 4100 Edmondson Ave Date signed 4/15/45

for Dr. J. R. Davis
Howard J. Maddox, M.D.

VS 150

G27928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. G27928

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2784 Alameda Blvd
(c) Hospital or institution: 9n
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2784 Alameda Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Lohrmann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife May Lohrmann
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Mar 11, 1868

8. AGE: Years	Months	Days	If less than one day
77	1	4	hr. min.

9. Birthplace Battimore Md
(Town, county, and state)

10. Usual Occupation Retired Baker

11. Industry or business

FATHER
12. Name Michael Lohrmann
13. Birthplace Germany

MOTHER
14. Maiden Name Sybilla Fehl
15. Birthplace Germany

16 (a) Informant May Lohrmann
(b) Address 2784 Alameda Blvd

17 (a) Burial (b) Date thereof Apr 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St.

APR 16 1945 [illegible] for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 15 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1-1945 to 4-15-1945 and that I last saw him alive on 4-14-1945

Immediate cause of death	Duration
Carcinoma descending Colon	1 year
Due to	
Due to	
Other Conditions Fracture in and	3½ mos.

(Include pregnancy within 3 months of death)

Date of operation Mar 2, 1945

Major findings of operation: Fracture in neck

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo B. Seybert M. D.

Address 1802 Harford Rd Date signed 4-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G27929 (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 W. Hadley Square
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dr. William D. Scott

April 15, 1945

3 (b) If veteran, name war: WORLD WAR I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mrs. Wm. D. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-80

8. AGE: Years	Months	Days	If less than one day
64	8	27	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name William D. Scott
13. Birthplace Virginia

MOTHER
14. Maiden Name Blanche Crutchfield
15. Birthplace Virginia

16 (a) Informant Hospital chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 18 1945 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address Mc Culloh & Orchard & Huntington Williams

19 (a) Date received by Local Registrar APR 16 1945 (b) Registered

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4-15 1945, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13 1945 to 4-14 1945, and that I last saw him alive on 4-14 1945

Immediate cause of death 15
Cardio-respiratory failure — Duration

Due to Congestive heart failure

Due to Hypertensive cardio vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred C. Hutchinson M. D.
Address 3088 34th St Date signed 4-15-45

VS 150

X

G27930
AB-92161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

G27930
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Henderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16- 1884

8. AGE: Years	Months	Days	If less than one day
60	5	0	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Balto City

FATHER
12. Name Robert Henderson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Croswell
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Avenue

18 (a) Funeral director William Cook Inc.
(b) Address 117 E. Lexington St.

19 (a) Date received by Local Registrar APR 16 1945 Registrar Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16- 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16- 1945 to 4-16 1945 and that I last saw h im alive on 4-16- 1945.

Immediate cause of death	Duration
Cardiac insufficiency	2
Emphysema	
Chronic bronchitis	
Due to Ca pulmonary	
Carcinoma of bladder	
Due to	
Other Conditions Carcinoma of bladder	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address E Woodward Date signed 4-16-45

Baltimore City Hospital 106 B

M. D. R. 1266-9

Doswell

3/43

HEALTH DEPARTMENT—CITY OF BALTIMORE

627931

627931

CERTIFICATE OF DEATH

93 E

1. PLACE OF DEATH

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1708 Edmondson Ave Ward)

Length of residence in city or town where death occurred 44 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME James Doswell 16 (Doswell)

(a) Residence: No. 1708 Edmondson Ave Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Doswell

6. DATE OF BIRTH (month, day, year) Oct 16, 1867

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Cement finisher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. paving

10. Date deceased last worked at this occupation (month and year) 1939

11. Total time (years) spent in this occupation 40 yrs

12. BIRTHPLACE (city or town) (State or country) Lutherville, Va. Virginia

FATHER

13. NAME Henry Clay Doswell

14. BIRTHPLACE (city or town) (State or country) Lunenburg Co Virginia

MOTHER

15. MAIDEN NAME Amelia Ann Holmes

16. BIRTHPLACE (city or town) (State or country) Lutherville Virginia

17. INFORMANT Gideon E. Doswell

(Address) 1325 Florida Ave. N.W. Wash. D.C.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Zion Cem. Date April 16, 1945

19. UNDERTAKER Thos. Cullen Hall

(Address) 1631 Druid Hill Ave

FILED APR 16 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 10, 1945

22. I HEREBY CERTIFY, That I attended deceased from April 1, 1945 to April 10, 1945

I last saw him alive on April 10, 1945 Death is said to have occurred on the date stated above, at 11 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis	1943
Other contributory causes of importance: Coronary Sclerosis	abt 1939

Name of operation None Date of

What test confirmed diagnosis? Physical Signs Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) John E. J. Camper M. D.

(Address) 639 N. Carey St., Balto., Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

G27932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G27932

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gwynn

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #2	212-12-6219

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/31/1919

8. AGE: Years	Months	Days	If less than one day
25	10	12	hr. min.

9. Birthplace Middlesex County, Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Woodlumb Gwynn
13. Birthplace Middlesex Co. Va.

MOTHER
14. Maiden Name Ida
15. Birthplace Va.

16 (a) Informant Ida (Ira) A. Gwynn (Mother)
(b) Address 111 N. Fremont Ave

17 (a) Burial (b) Date thereof 4/16/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore County, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (b) Huntington Williamsburg, Md

APR 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1945 at 3.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1945 to 4/12 1945, and that I last saw him alive on 4/12 1945.

Immediate cause of death	Duration
Respiratory Failure.	
Due to Toxic - Meningitis Encephalitis	
Due to Methyl Alcohol.	
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy T.P.X.A. Liver Changes & Brain Changes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Lamm M. D.
Address Univ. Hosp. Date signed 4/17/45

The G27933 6 copies

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G27933

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 N. Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N. Belnord Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kokta (Cody)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single, married, widowed, or divorced~~ Married

6 (b) Name of husband or wife Mary G. Kokta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1895

8. AGE: Years 50 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Helper, Machine Shop
11. Industry or business

FATHER 12. Name Charley Kokata
13. Birthplace Bohemia

MOTHER 14. Maiden Name Josefa Benedict
15. Birthplace Bohemia

16 (a) Informant Benedetta Kokta
(b) Address 818 N. Belnord a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Cracchiolo
(b) Address 900 N. Chester St

APR 16 1945 (Date received by Registrar)

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 109 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13 1945 to 4-14 1945 and that I last saw him alive on 4-13 1945

Immediate cause of death Coronary Occlusion — Duration Sudden

Due to Cardio Renal Complications

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Dew M.D.
Address 2901 E. Monument St Date signed 4/16/45

1310

627934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 24B

Registered No. 627934

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Aves.
(c) Hospital or institution West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~James~~ Joseph Leroy MITCHELL

3 (b) If veteran, name war No

3 (c) Social Security Account No. 219-07-1100

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary H. Brunner Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1905

8. AGE: Years 39 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Painter & Decorator

11. Industry or business

FATHER
12. Name Francis Mitchell
13. Birthplace Lansdale Pa

MOTHER
14. Maiden Name Mary Schleve
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mary H. Mitchell
(b) Address 330 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4439 Belair Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) Date received by Registrar APR 16 1945 (b) Huntington Williams M.D. Registrar

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 12 1945, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1945 to 4/12 1945 and that I last saw h. alive on 4/12 1945.

Immediate cause of death Portal cirrhosis — Duration

Due to

Due to

Other Conditions Congestive Heart failure - phalebo
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Silberfeld M. D.
Address West Balt. Gen. Hosp. Date signed 4/13/45

G27935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G27935

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 N. Bradford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Bradford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Lahner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife. Margaret Lahner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1867

8. AGE: Years	Months	Days	If less than one day
77	8	28	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Blacksmith Helper

11. Industry or business Balto Transit Co

FATHER
12. Name John H. Lahner
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Lahner
(b) Address 1512 N. Bradford St

17 (a) Burial (b) Date thereof 4-16th 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo F. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b) Huntington Williams, Md.

APR 16 1945

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13th 1945, at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1945, to 4/13 1945, and that I last saw h alive on 4/13 1945

Immediate cause of death	Duration
Broncho-pneumonia	5 days
Due to Uremia	6 Wks ?
Due to Hypertrophied Prostate	2 Yrs ?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Karl Grossman M. D.
Address 1212 N. Patterson Pk Ave Date signed 4/14/45

G27936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27936 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2830 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6-5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 Elliott St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna Antczak

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Ignacy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1876

8. AGE: Years	Months	Days	If less than one day
68	7	24	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Bertha Piechocha
(b) Address 2830 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Fialkowski Inc.
(b) Address 1000 S. Kenwood Ave.

19 (a) APR 16 1945 Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945 to April 13 1945; and that I last saw her alive on April 12 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Angina Pectoris	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Lally M.D.
M. D.
Address 3517 Edmondson Ave. Date signed 4/16/1945

VS 150

G27937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27937
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Calhoun St.
(c) Hospital or institution: Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2142 2 St. N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Dowell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 19 1945 (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Washington, D.C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) (Date received by registrar) (b) Registrar

APR 15 1945

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1945 at 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Reuben M.D.
Medical Examiner.
Date signed 4/16/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G27938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp., Lombard & Green Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2637 Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Hardtner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) 1

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state) L

10. Usual Occupation L

11. Industry or business L

FATHER
12. Name L
13. Birthplace L

MOTHER
14. Maiden Name L
15. Birthplace

16 (a) Informant Alice Hardtner } Patient
(b) Address 2637 Charles St

17 (a) Alexandria, Virginia 4/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Alexandria, Virginia

18 (a) Funeral director John A. Noack
(b) Address 3000 Baltimore St.

19 (a) APR 16 1945 Huntington, W. Virginia, M.F.
(Registered by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 1945, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 4/16 1945, and that I last saw her alive on 4/16 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Coronary Heart Disease	
Due to Pre-existing Pulmonary Edema	
Due to Pre-existing Angina Pectoris	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Rosberg Jr.
Address Univ. Hosp. Date signed 4/16/45

X

G27939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G27939 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2672 Lehman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2672 Lehman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alphonsine Hefner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Leander Hefner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Nicholas Hefner
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Deindl
15. Birthplace Germany

16 (a) Informant Mary Murdock
(b) Address 2672 Lehman St

17 (a) (Burial, cremation, or removal) (b) Date thereof April 17 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) (b) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

APR 16 1945

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1945 to 4/14 1945 and that I last saw him alive on 4/13 1945.

Immediate cause of death: General Carcinomatosis — Duration 5 Wks.

Due to Carcinoma of Pancreas — Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Fredrick Ave Date signed 4/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ed Abair

G27940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G27940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6009 Edna Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6009 Edna Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernhardt August Hoffmeister

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Theresa Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27-1868

8. AGE: Years 76 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Albert Hoffmeister

13. Birthplace

MOTHER 14. Maiden Name Margaret Stein

15. Birthplace

16 (a) Informant Mrs Theresa Hoffmeister

(b) Address 6009 Edna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Leonard J. Kuck

(b) Address 5305 Harford Rd.

19 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1945 at 6P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1942 to 4/14 1945 and that I last saw h[im] alive on April 14 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: April 14, 1945

Due to: Generalized arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theresa

Address 6217 Harford Rd Date signed 4/16/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

X

G27941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1382

Registered No. G27941

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 Ailsa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Ailsa Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roland Watson

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mardella

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) July 11-1887

8. AGE: Years 57 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Charles Watson
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Catherine Brown
15. Birthplace Balto - Md

16 (a) Informant Mrs. Mardella Watson
(b) Address 2403 Ailsa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)
(c) Cemetery or crematory Balto-National
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 6 1945 (b) Rec'd by registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14-1945 at 9 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1945 to 4-14 1945 and that I last saw him alive on 4-13-1945

Immediate cause of death: Pulmonary Tuberculosis — Duration 15 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home or on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature [signature]
Address 5217 York Rd Date signed 4/16/45

G27942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (~~[illegible]~~ days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6061 Falls Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Louis Becker – M.J. Becker

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-2839

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary L. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25 - 1873

8. AGE: Years	Months	Days	If less than one day
72	2	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation ~~Pharmacist~~
11. Industry or business Druggist

FATHER
12. Name August F. Becker
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Mary F. Becker
(b) Address 6061 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Kuck
(b) Address 5306 Harford Road

19 APR 9 1945 (Date rec'd by registrar) Huntingtown, Md. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/45 1945, at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/45 19 to 4/15 1945, and that I last saw him alive on 4/13/45 19

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Hypostatic Pneumonia	
Due to Ca of head of Pancreas	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/13/45
Major findings of operation Ca Head of Pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Cavanaugh M. D.
Address St. Joseph's Hosp. Date signed 4/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47179627943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

627943 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil.
(c) City or town North East.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box - 104
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sprawn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Regina

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 4-6-62

8. AGE: Years	Months	Days	If less than one day
83	-	10	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Sprawn
13. Birthplace N. C.

MOTHER
14. Maiden Name Anastasia McNamara
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Elkton Md
18 (a) Funeral director Joseph A. Spaur
(b) Address North East Md

19 (a) Apr 19 1945 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 5.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1945 to April 16 1945 and that I last saw him alive on April 16 1945

Immediate cause of death	Duration
Cardiac arrest	
Due to Myocardial infarction	
Due to Arteriosclerotic heart	
Other Conditions Disease	
Renal Systemic	
Due to Chronic nephritis	

(Include pregnancy within 3 months of death)

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury
23. Signature William J. Dixon
Johns Hopkins Hospital 4/16/45
(Address) (Date signed)

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

627944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

627944 Registered No. 12212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Regina McGrath
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ James J. McGrath
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1900

8. AGE: Years	Months	Days	If less than one day
45	3		hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred S. Cross
13. Birthplace Balto Md

MOTHER
14. Maiden Name Regina Sullivan
15. Birthplace Balto Md

16 (a) Informant Mr Alfred Cross
(b) Address 500 N. Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem
Location Balto - Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 E. Hanover St

19 (a) (Interred by) (b) Registrar

APR 16 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1945, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1945, to 4/13 1945, and that I last saw h[illegible] alive on 4/13 1945.

Immediate cause of death	Duration
Acute Congestive Heart Failure	12 hrs.
Due to Hypertensive Cardio-Vascular Disease	2
Due to	
Other Conditions Uterine Obstruction ? P.D. adhesions	2 days

(Include pregnancy within 3 months of death)
Date of operation 4/13/45
Major findings of operation: Uterine Obstruction due to P.D. adhesions
of autopsy: — none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature Sigmund Cohen M. D.
Address 1 W. Lexington St Date signed 4/16/45

627945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

627945 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write cause of death is especially important. MARGIN RESERVED FOR HOLDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd Bledsoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Thula Bledsoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1903

8. AGE: Years	Months	Days	If less than one day
42	11	6	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Balto. Gen. Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)

(c) Cemetery or crematory
Location Bristol, Va.

18 (a) Funeral director Martin Baker & Sons
(b) Address 1827 W. North Ave

19 (a) APR 16 1945 (Date received by registrar) (b) at Washington Hill Mortuary

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945, at 10 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 14 1945 9 15 A.M.
(b) Where did injury occur? Fort Smallwood Road
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert L. Bratton, M.D.
Medical Examiner.
Date signed April 15 1945

G27946

J0#92476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27946 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Piedmont Ave. 3410 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Edward Cormelia Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1881

8. AGE: Years	Months	Days	If less than one day
63	4	19	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Unable to obtain information.

11. Industry or business " " " "

FATHER
12. Name Alexander (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Hattie Coldman
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1945, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 8, 1945, to Apr. 7, 1945, and that I last saw him alive on Apr. 7, 1945.

Immediate cause of death Coronary Occlusion — Duration 16 Min

Due to

Due to

Other Conditions Arteriosclerotic heart disease — 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Shellhorst M. D.
Address Balt. City Hosp. Date signed 4-13-45

2058

G27947

BALTIMORE CITY HEALTH DEPARTMENT

TN. 92114 **CERTIFICATE OF DEATH** 95B Registered No. G27947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Briscoe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4th, 1894

8. AGE: Years 51 | Months 0 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name Mary Briscoe
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) APR 17 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd. 1945 19 ..., at 5.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13, 19 45 to Apr. 2 19 45 and that I last saw him alive on April 2nd 19 45

Immediate cause of death	Duration
Cardiac Failure	?
Due to Rheumatic Heart Disease	?
Due to	
Other Conditions Mesenteric Subacute Bacterial Endocarditis	10 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 4-13-45

5057

G27948

CWK-92922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27948 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Yanos or James Jance -or James Janu

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-3168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. ? 1881

8. AGE: Years	Months	Days	If less than one day
63	6	?	hr. min.

9. Birthplace Czecko-Slovakia
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Jacob Yanos
13. Birthplace Czecko-Slovakia

MOTHER
14. Maiden Name Edna ?
15. Birthplace Czecko-Slovakia

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 17 1945 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945, at AM 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 7 1945, and that I last saw him alive on April 7 1945.

Immediate cause of death Cardiac arrest

Due to arteriosclerotic heart disease + hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

Duration
7
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. M. Bullock M. D.
Address Balto. City Hosp. Date signed 4-13-45

G27949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G27949 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 East Oliver St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 E. Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Johanna Meller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9-1931

8. AGE: Years	Months	Days	If less than one day
13	5	5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation School girl
11. Industry or business

FATHER
12. Name John C. Meller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frieda J. Mueller
15. Birthplace Baltimore Md.

16 (a) Informant Frieda J. Meller
(b) Address 2435 East Oliver St

17 (a) Burial (b) Date thereof April 18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) APR 17 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1945, at 3.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945 to 4-14 1945 and that I last saw h[er] alive on 4/14 1945

Immediate cause of death Mononucleosis, infectious — Duration 6 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucius E. Leute M. D.
Address 1011 Madison St Date signed 4-17-45

X

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56B

G27950
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 N. Carey St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 N. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Lee Crawford
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-10-9471

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(City or town, county and state)

10. Usual Occupation Telephone Operator
11. Industry or business Bell Telephone Co.

FATHER
12. Name John Doubtfire
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Kate Farmer
15. Birthplace Hagerstown Md

16 (a) Informant Mrs. Wellington Crawford
(b) Address 1315 Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Lorty

18 (a) Funeral director W. A. Brooks
(b) Address 1463 N. Carey St

19 APR 17 1945 (b) Huntington Williams, M.D.
(Date received by local Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to April 14 1945 and that I last saw h alive on April 14 1945

Immediate cause of death: Acute dilatation of the heart — Duration 3 days
Due to Uremia chronic Nephritis
Due to Intravenous Tetrol Injection
Other conditions?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis
Address Supt Health Date signed April 17 1945

X

G27951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 D

G27951 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 3210 Eastern Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas B Pierpoint

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Caroline Pierpoint
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1864

8. AGE: Years	Months	Days	If less than one day
80	9	20	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Thos B. Pierpoint
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Lynnich
15. Birthplace Balto

16 (a) Informant Mrs Chas Fuller
(b) Address 7111 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) APR 17 1945 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 2 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1944 to 4/16 1945 and that I last saw h[illegible] alive on 4/15 1945.

Immediate cause of death	Duration
Carcinoma of pancreas	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charlotte Flom M.D.
Address 3211 Eastern Ave Date signed 4/16/45

X Flom

G27952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27952 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4802 Richard Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71/4o

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 4802 Richard Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John David Slotke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna May Slotke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1862

8. AGE: Years	Months	Days	If less than one day
82	10	—	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Gardener
11. Industry or business

FATHER
12. Name John Slotke
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Schmidt
15. Birthplace Germany

16 (a) Informant John F. Slotke
(b) Address 4802 Richard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Bells Cem
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2045 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to April 16 1945 and that I last saw him alive on April 13 1945.

Immediate cause of death: hypertensive Cardiovascular Disease — Duration: 1 year

Due to:

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz G. Hunyan M. D.
Address 700 Hartford Date signed 4/16/45

VS 150

Huntington Williams, M.D.

G27953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 D G27953 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denmead St
(c) Hospital or institution: Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3127 Dillon
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Huber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Huber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1864

8. AGE: Years 81 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business Continental Can Co

FATHER
12. Name Charles W Huber
13. Birthplace Ger

MOTHER
14. Maiden Name Doud
15. Birthplace Penn

16 (a) Informant Mrs Elizabeth Huber
(b) Address 3127 Dillon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18/45 (month) (day) (year)

(c) Cemetery or crematory MtCarmel
Location Balto Md

18 (a) Funeral direction Welsh Funeral Home
(b) Address 2266 Dillon St

APR 17 2266

19 (a) (Date rec'd by registrar) (b) Huntington West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945, to April 15 1945 and that I last saw h in alive on April 15 1945.

	Duration
Immediate cause of death: Myocarditis	2 wks
Due to Advanced arteriosclerosis	?
Due to	about 3 weeks
Other Conditions Cystitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold D Tibbitt
Address 2220 Garrison Blvd Date signed April 16/45

X

G27954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G27954

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 E Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 E Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bruce Jackel

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-05-4004

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary E Jackel
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 2/11/1872

8. AGE: Years 70 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Bakery

FATHER
12. Name Jacob Jackel
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Stoffel
15. Birthplace Balto

16 (a) Informant Wm L Jackel
(b) Address 6123 Deptford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Cath

18 (a) Funeral director Wenrich Funeral Home
(b) Address 2119 E. Orleans St

19 (a) APR 17 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945 at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 14 1945 and that I last saw h alive on April 14 1945.

Immediate cause of death	Duration
Coronary Artery Thrombosis	2 Days
Due to	
Due to	
Other Conditions Acute Cholecystitis	12 Days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 2025 E North Ave Date signed 4-14-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

G27955 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N Kenwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N Kenwood (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Bohmer

3 (b) If veteran, name war: Spanish Amd
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Martha Bohmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22 1870

8. AGE: Years 75 | Months - | Days 24 | If less than one day: hr. min.

9. Birthplace Cleveland Ohio (Town, county, and state)

10. Usual Occupation Cooper

11. Industry or business

FATHER 12. Name Wm H Bohmer
13. Birthplace Germany

MOTHER 14. Maiden Name Charlotte Rothley
15. Birthplace Germany

16 (a) Informant Wm H Bohmer
(b) Address 25-37 Arunah ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2098 Pulaski St

19 (a) APR 17 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Hypertensive Cardio Vascular Disease

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

Acute Myocarditis of autopsy: Arteriosclerosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Fred Penda M.D.
Address 100 N Dulaney Pl Date signed 4-7-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

G27956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13a G27956

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Auchentoroly Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 W. North Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH PFEFFERKORN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Sigmund Pfefferkorn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 31, 1860.

8. AGE: Years	Months	Days	If less than one day
85		14	hr. min.

9. Birthplace Austria. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nathan Pfefferkorn,
13. Birthplace Austria.

MOTHER
14. Maiden Name Unknown,
15. Birthplace Austria.

16 (a) Informant Mr. Alfred Pfefferkorn,
(b) Address 1320 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/45. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director David Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 APR 17 1945 (Date rec'd by registrar) (b) Huntington Mill Funeral Home, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th. 19 45 at 6.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945. to April 14 1945.
and that I last saw her alive on April 14 1945.

Immediate cause of death
Cerebral Hemorrhage
Bronchial Pneumonia
Due to Generalized Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3 days
1 day.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 2322 Callow Ave. Date signed 4/15/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

472937 ✓ 126 6-27957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Eastern Ave & Baylands Baltimore Co (If in institution, give name)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Rae S Nordlinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Ellis Nordlinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-72

8. AGE: Years	Months	Days	If less than one day
73	7	21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Schloss
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Kahn
15. Birthplace Germany Records

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 Cremation (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery ~~crematory~~ Loudon Pk.
Location Balto. Md.

18 (a) Funeral dir. Bride Funeral Home
(b) Address 1902 Eastern Ave

19 (a) APR 17 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April-16 1945, at 4:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April-13 1945, to April-16 1945, and that I last saw her alive on April-16 1945.

Immediate cause of death	Duration
Heart failure	
Due to Peritonitis	1 day
Due to Rupt Gall Bladder	1 day
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-15-45

Major findings of operation: Rupt. gall bladder (Fresh)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter Heldman M.D.
Address 4-16-45 Date sig

Herrington for Hillcoat, M.D.

VS 150

G27958 3 BALTIMORE CITY HEALTH DEPARTMENT ✓ G27958
Registered No.

CERTIFICATE OF DEATH 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 W. Fayette St.
(c) Hospital or institution: ✓0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Hipsley

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Wm. H. Hipsley
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	6	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Lanhardt
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Balto. Md.

16 (a) Informant Mr. Wm. Hipsley
(b) Address 2222 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 19 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Frederick Md.

18 (a) Funeral director Fred. A. Krauss & Bro.
(b) Address 1216 N. Charles St.

19 (a) APR 17 1945 (b) Huntington Willi (Registrar's signature) (Registrar, Baltimore City)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1944 to 4/15 1945
and that I last saw her alive on 4/15 1945

Immediate cause of death Myocardial Degeneration. Duration ?

Due to Arteriosclerosis. ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel E. Bogard, M.D.
Address 1905 W. Baltimore Date signed 4/17/45

G27959

BALTIMORE CITY HEALTH DEPARTMENT ✓ G27959

CERTIFICATE OF DEATH 170B

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 N. Ellamont St.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Vernon Charles Klages

3 (b) If veteran, name war	3 (c) Social Security Account No.
World 1	212-10-6450

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hilda May Klages
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 8th 1894

8. AGE: Years	Months	Days	If less than one day
50	4	8	.....hr. .....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Route Foreman
11. Industry or business Koester Baking Co.,

FATHER
12. Name Fred Herman Klages
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Carrie Carl
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Thelma K. O'Neal
(b) Address 1614 Ellamont Street.

17 (a) Burial (b) Date thereof April 19-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) Apr 17 1945 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 8:55 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull, fracture of pelvis, fracture of left leg & right arm

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-16-45 at 80' S. Reisterstown Rd. 25/2 M.
(b) Where did injury occur? Hanover St. Bridge
(c) Did injury occur at home, on farm, industrial place, or public place? Roadway While at work? No
(d) Means of injury Collision with Interstate truck

23. Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed 4-16-45

(OVER)

G27960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Liberty Heights Avenue.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md? (b) County ----
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Liberty Heights Avenue. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Dexter Hudgins

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 228-10-3846

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lucy P. Hudgins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 1 1891

8. AGE: Years 53 | Months 7 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Inventory Surveyor

11. Industry or business Maratime Commission

FATHER
12. Name Joseph E. Hudgins
13. Birthplace Virginia

MOTHER
14. Maiden Name Charlotte Walters
15. Birthplace Pennsylvania

16 (a) Informant Mrs Lucy P. Hudgins
(b) Address 4010 Liberty Heights Ave.,

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 17th 1945 (month) (day) (year)
(c) Cemetery ~~Loudoun~~ Sunset
Location Christiansburg, Virginia

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address ...more, Maryland

APR 17 1945

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945, at 1.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1945, to April 14 1945, and that I last saw him alive on 4/12 1945.

	Duration
Immediate cause of death: Coronary occlusion	2 days
Due to: myocardial insufficiency	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lewman M. D.
Address 4004 Liberty Hgts Ave Date signed 4/16/45

VS 150

G27961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G27961 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Weaver Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Weaver Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ALBERT NAENY

3 (b) If veteran, name war: ----

3 (c) Social Security Account No. ----

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hermie Hall

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 2 1872

8. AGE: Years 72 | Months 10 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Naeny
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Hermie H. Naeny
(b) Address 3101 Weaver Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 4-17-1945 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, at 4 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18-1933 to 4-15-1945 and that I last saw h[illegible] alive on 4-15-1945.

Immediate cause of death	Duration
Hypertensive cardiac disease	12 yrs.
Due to	
Due to	
Other Conditions Chronic nephritis	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm B. Sybert M. D.
Address 2807 Harford Rd. Date signed 4-18-45

G27962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

G27962 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 29
(b) Street address No. 5002 Frederick Rd.
(c) Hospital or institution:
The Sunday Sanitarium - attd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Frederick Avenue.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elizabeth F. Coffin

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	widow

6 (b) Name of husband or wife John Coffin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1864

8. AGE: Years	Months	Days	If less than one day
80 XX	XX 9	24	hr. min.

9. Birthplace Radnor, Pennsylvania
(Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business

FATHER
12. Name Milton Fussell
13. Birthplace Pa.

MOTHER
14. Maiden Name Tamar Haldeman XXXXX
15. Birthplace Pa

16 (a) Informant Louis F. Coffin (Son)
(b) Address 520 C. Spanglers Pt. Md.

17 (a) Buried Removal (b) Date thereof 4/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johnstown, Pa.
18 (a) Funeral Director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.
Huntington Williams
19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1940, to April 16 1945, and that I last saw her alive on April 16 1945

Immediate cause of death	Duration
Coronary Thrombosis	a few minutes
Due to Arteriosclerosis	Years
Due to	
Other Conditions Question of malignancy in thyroid	about 1 yr

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rachel K. Sunday M. D.
Address The Sunday Sanitarium attd Date signed 4-16-45

G-27963
470304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G27963
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Forge Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. Ridgely.
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-09-4928

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	married

6 (b) Name of husband or wife Mary Ridgely
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-14

8. AGE: Years	Months	Days	If less than one day
30	5	29.	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business W. School Board

FATHER
12. Name Stanley Ridgely
13. Birthplace Md.

MOTHER
14. Maiden Name Irene Burgee
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 18-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) APR 17 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1945 to April 15 1945, and that I last saw him alive on April 15 1945.

Immediate cause of death	Duration
Tuberculous Meningitis	2 weeks
Due to	
Due to	
Other Conditions T.B. Spine	

(Include pregnancy within 3 months of death)
Date of operation 3/15/45
Major findings of operation: T.B. Spine
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Huntington Williams Jr. M. D.
Address Johns Hopkins Hosp. Signed 4-17-45

X

G27964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N Poppleton 18
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 117 N Poppleton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Estella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1894

8. AGE: Years	Months	Days	If less than one day
50	10	4	hr. min.

9. Birthplace Henderson, N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joshua Martin.
13. Birthplace Henderson, N.C.

MOTHER
14. Maiden Name Nannie Revis
15. Birthplace Warrington, N.C.

16 (a) Informant Mrs. Estella Martin
(b) Address 117 N. Poppleton St.

17 (a) Burial (b) Date thereof Apr. 14 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 (a) (b) Huntingdon Williamsburg Pa

(Date rec'd by registrar) APR 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945 at 9:30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945 to April 14 1945.
and that I last saw h alive on 4/14/45

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 3 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 736 Lexington Date signed 4/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G27965 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2106 Eutaw Place~~ Balto.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Weinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Minnie Weinstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1887

8. AGE: Years 57 | Months 9 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name Rubin Weinstein
13. Birthplace Russia

MOTHER
14. Maiden Name Rona Snyder
15. Birthplace Russia

16 (a) Informant Wife
(b) Address 2106 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem.
Location Hamilton ave

18 (a) Funeral director S. of Freeman & Bro
(b) Address 1124-36 W Mt. Royal ave

19 (a) ..... (b) ..... (Date rec'd by registrar) (Registrar)

VS APR 17 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1945 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1945 to 4/16 1945 and that I last saw him alive on 4/16 1945

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Pyelonephritis	
Due to Hypertension & Cardio-Vascular Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/4/45

Major findings of operation: Hemorrhoidectomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas L. Bell M. D.
Address Mercy Hosp. Date signed 4-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G27966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27966

Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 807 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Erastus Evans

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	married

6 (b) Name of husband or wife Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1890

8. AGE: Years	Months	Days	If less than one day
54	10	13	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Evans
13. Birthplace N. C.

MOTHER
14. Maiden Name Helen
15. Birthplace N. C.

16 (a) Informant Sadie Washington
(b) Address 807 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pressman St

19 (a) APR 17 1945 (Date received by registrar) (b) Huntingtown Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 , at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 19 45 to April 14 45, and that I last saw [illegible] alive on April 13 19 45.

Immediate cause of death Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 4-17-45

X

G27967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27967

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the certificate filled out correctly. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4120 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 37 years and

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4120 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose Schwartz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Harry Schwartz
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Lena Schwartz
(b) Address 4120 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)
(c) Cemetery or crematory Shaarai Tfileh Cong
Location Lemon Mill Road

18 (a) Funeral director Jack Levin Inc.,
(b) Address 1431 E Baltimore St

19 (a) (Date received by Registrar) APR 17 1945 (Registrar) Huntington Hollander, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15 1945, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1944 to Apr 16 1945, and that I last saw h alive on Apr 15 1945.

Immediate cause of death Myocarditis
Coronary thrombosis
Due to
Due to Advanced arterio-sclerosis
Other Conditions

Duration
Chronic 6 Mo
Sept. 27/44

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Tarbell M. D.
Address 22 30 Garrison Blvd
Date signed Apr 16 45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

AB-627968 627968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 4mos-12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Perlett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-1872

8. AGE: Years	Months	Days	If less than one day
72	10	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Zachariah Perlett (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Kenny (D)
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director John A. McDan
(b) Address 3500 E. Balto. St.

19 (a) APR 17 1945
(Date Rec'd by Registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15- 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23-43 1943, to 4-15- 1945, and that I last saw him alive on 4-15- 1945.

Immediate cause of death	Duration
(a) Arteriosclerotic heart disease.	7
(b) Congestive failure	
Due to	
Due to	
Other Conditions	?

Chronic bronchitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. M. Phillips M.D.
Address Balto. Md. Date signed 4-17-45

X

G27959 X G27969

AB-92834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1960

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Ave. 2 Glenwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Kreft

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Tillie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4- 1866

8. AGE: Years	Months	Days	If less than one day
79	3	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Kraft (D)
13. Birthplace ?

MOTHER
14. Maiden Name Sophie ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilhom Co Inc
(b) Address 1214 Gould St

19 (a) (Registrar's signature) (b) Huntington Williams M.D.
APR 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15- 1945, at 9.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29- 1945, to 4-15 1945, and that I last saw him alive on 4-15- 1945.

Immediate cause of death Bronchopneumonia & Uremia — Duration
Due to Chronic Nephritis
Generalized Arteriosclerosis
Due to Senility
Other Conditions Enterocholecystitis
Fract. Left Femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-1-44 at P. M
(c) Where did injury occur? 2 Glenwood Rd., Essex
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No.
(Specify type of place)
(e) Means of injury Slipped on Rug at home & fell.
23. Signature J R Miller M.D.
Address City Hosp. Date signed 4-16-45
Per J.E. Olivia

To be approved by Medical Examiner Howard J. Malden, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G27970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 560

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 874 Washington Blvd
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a.a.
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Florence Loetell

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband John O. B. Loetell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23rd 1878

8. AGE: Years 66 | Months 3/12 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Gustavus Rudiger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Roder
15. Birthplace Balto. Md.

16 (a) Informant Walter F. Loetell
(b) Address Pasadena Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) APR 17 1945 (Date received by Registrar) Huntington Wellsville, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1945 9:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 19 45 to April 14 19 45, and that I last saw h[illegible] alive on 4-14 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 Day

Due to Hypertension Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 5, 1945

Major findings of operation: Hyp. Cystic Ovary (2000 cc.)

of autopsy: Clinical findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 540 [illegible] Date signed 4-16-45

83a

G27971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G27971 Registered No. 548a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Catonsville
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Fontaine Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah Block

3 (b) If veteran, name war No

3 (c) Social Security Account No. 24-01-2884

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1883

8. AGE: Years 52 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Hospital Child

FATHER
12. Name Charles H Higgs
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Minnie Penn
15. Birthplace Cumberland Md

16 (a) Informant Mrs Minnie Block
(b) Address 3318 Elmora Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros
(b) Address 1347 Pennsylvania Ave

19 (a) APR 17 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1945, to Apr 16 1945, and that I last saw h alive on 19

Immediate cause of death Heart failure — Duration

Due to Cerebral Hemorrhage — Duration

Due to I generalized intentions — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jose D Ribeiro de Andrade M. D.
Address St Agnes Hosp Date signed 4/16/45

VS 150

AB 627972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G27972 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- 80?

8. AGE: Years	Months	Days	If less than one day
80 ?	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave. Apr 18-45

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Prospect

18 (a) Funeral director Sam'l W. Chase & Son
(b) Address 458 N. Gilmor St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15- 1945, at 4.40AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1945, to 4-15- 1945, and that I last saw him alive on 4-15- 1945.

Immediate cause of death	Duration
Bronchopneumonia	7
Due to organism unknown	
Due to	
Other Conditions Senility (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations:	
of autopsy: as above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. M. Phillippi
Address Balto City Hosp Date signed 4-16-45

VS 150 APR 17 1945

Huntington Williams, M.D.

G27973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G27973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 N 21st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. 21st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Essex G Floyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Mary Floyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4-1887

8. AGE: Years	Months	Days	If less than one day
57	7	12	hr. min.

9. Birthplace Easton Md
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Railway Bus Co

FATHER
12. Name Edmond Floyd
13. Birthplace Md

MOTHER
14. Maiden Name Martha Williams
15. Birthplace

16 (a) Informant Mary E. Floyd
(b) Address 200 N. 21st St

17 (a) Burial (b) Date thereof Apr 20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Easton
Location Easton Md

18 (a) Funeral director Samuel F Chase Undr
(b) Address 638 N. Gilmor St

19 (a) APR 17 1945 (b)
(Date received by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1945 to 4/16 1945; and that I last saw h— alive on 4/15 1945.

Immediate cause of death	Duration
Hyperpyrexia Cardiac Renal	
Due to	
Due to	
Other Conditions	12 Da

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address 17 W Lafayette Ave Date signed M. D. 4/17/45

X

G27974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G27974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 922 N. Strieker St
(b) Street address
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Strieker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis E. Ford

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1905

8. AGE: Years 76 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Balto., Md. (town, county and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Shepperd Shields

13. Birthplace Md.

MOTHER 14. Maiden name Fannie Smith

15. Birthplace Md.

16 (a) Informant Fannie Shields

(b) Address 922 N. Strieker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 19-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location E. J. Co. Md

18 (a) Funeral director Sam'l W. Chase & Bro

(b) Address 638 N. Gilmor St

19 (a) (Date rec'd by reg.) APR 17 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14/45 19 to 4/16/45 19 ; and that I last saw h[illegible] alive on 4/16/45

Immediate cause of death (a) Coronary Thrombosis

Due to (b) Hypertension Arteriosclerosis

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. Cecil Stein M. D.

Address 624 York Date signed 4/17/45

X

G27975 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G27975

CERTIFICATE OF DEATH 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 myrtle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johna Lawson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or ~~divorced~~ W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1879

8. AGE: Years 65 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Penn. R.R

FATHER 12. Name Newton Lawson

13. Birthplace Va

MOTHER 14. Maiden Name Lala Smith

15. Birthplace Va

16 (a) Informant Ruth Lawson Richmond Va

(b) Address 1123 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Sam'l K. Chase Funeral Home

18 (a) Funeral director

(b) Address 1300 N. Gilmore

19 (a) (b) Huntington West Virginia

APR 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 19, to April 14 1945, and that I last saw h alive on April 14 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Hr

Due to:

Due to:

Other Conditions: Diabetes — Duration: 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 1063 myrtle ave Date signed 4-17-45

63a

G27976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓9

Registered No. G27976

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Josephine Davis ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Col	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1944

8. AGE: Years	Months	Days	If less than one day
0	8	5	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Ervin Davis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Leighton
15. Birthplace Baltimore

16 (a) Informant Emma Davis
(b) Address 118 W. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Bristol Hill Ave

APR 17 1945 (c) Huntington Williams, M.D.
Date received

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19..., at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1945, to 4-16 1945, and that I last saw h[illegible] alive on 4/16 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Pertussis	3 weeks
Due to H. Pertussis	
Other Conditions Pneumococcal Pneumonia	4 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 4-16-45

X

G27977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G27977 Registered No.

MARGIN RESERVED FOR BINDING

USE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3804 Barrington Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Barrington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ella Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24 1875

8. AGE: Years 69 | Months 7 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Clerk.

11. Industry or business

FATHER 12. Name ? Smith

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Wm. T. Perkins

(b) Address 3804 Barrington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md

18 (a) Funeral director Wm. [illegible] Sons

(b) Address [illegible] Huntington Ave, Baltimore, Md

19 (a) APR 17 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/45, at 10:00 AM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh W. B. McNally M.D. Medical Examiner.

Date signed 4/16/45

VS 151

G27978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G27978

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Park Ave.
(c) Hospital or institution: Baptist Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1870

8. AGE: Years 74 | Months 6 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Sanders
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Willis
15. Birthplace Md.

16 (a) Informant Records - Baptist Home
(b) Address 1615 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)
(c) Cemetery Mount Olivet
Location Frederick Ave., Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

APR 17 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS t50

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 12-40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Apl. 17 1945, and that I last saw her alive on 4/15 1945.

Immediate cause of death: Apoplexy — Duration: 9 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R Johnson M. D.
Address Medical Arts Bldg. Date signed

Dr Wm. Johnson X

627979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1702 627979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 Augusta Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lewellyn Miller
6 (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Johnson, South Carolina (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Hozeiah Miller
13. Birthplace Johnson, South Carolina

MOTHER
14. Maiden Name Estella Miller
15. Birthplace Johnson, South Carolina

16 (a) Informant Ulmea Miller (Brother)
(b) Address K-111, Fairfield Md.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Apr. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Johnson, South Carolina

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson

19 (a) APR 17 1945 (b)
(Filed by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 45 - 3:30 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck

Due to

Other Conditions Ruptured heart + liver
Multiple fractures
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-16-45 at 12:37 A. M. Balto. Co.
(b) Where did injury occur? B & O R.R. Myers Crossing & Fallon Ring Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto stuck on B & O track - while trying to push it off - train struck him

23. Signature Homer L. Wallace M.D.
Medical Examiner.
Date signed April 16, 1945

Hunting for Witness

G27980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G27980 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 No Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 No Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sol Jaffe

3 (b) If veteran, name war
3 (c) Social Security account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Lith
(Town, County, and State or Country)
10. Usual Occupation Conf. Store
11. Industry or business

FATHER
12. Name Harry Lith
13. Birthplace

MOTHER
14. Maiden Name Eeba Lith
15. Birthplace

16 (a) Informant Irving Cooper
(b) Address 4007 Boardman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tefileth Cong
Location Windsor Mill Road

18 (a) Funeral director Jacob Levine Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by local registrar) APR 17 1945 Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16- 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944 to Apr. 16 1945, and that I last saw him alive on Apr. 16 1945.

Immediate cause of death	Duration
Coronary Occlusion	10 days
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions Multiple Aneurisms	6 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Herbert Goldstone
23. Signature
Address 2203 Linden Av. Date signed Apr. 17. M.D.

X

G27981 471447 Square #4 627981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a Registered No.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842 E. Pratt St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** James Fawcett.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-1889.

8. AGE: Years	Months	Days	If less than one day
55	11	13	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Work.
11. Industry or business

FATHER
12. Name James Fawcett.
13. Birthplace Germany.

MOTHER
14. Maiden Name Emma Widow
15. Birthplace France

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location PUBLIC CEMETERY APR 17 1945
18 (a) Funeral director..... Commissioner of Health
(b) Address.....
19 (a) APR 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April - 2 - 1945, at 5.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from March - 30 1945, to April - 2 1945, and that I last saw him alive on April - 2 1945.

Immediate cause of death: Hemorrhage from
Due to Peptic ulcer
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature William J. Dieffenbach M.D.
Address Johns Hopkins Hospital 4/19/45

VS 180

G27982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 140C

Registered No. G27982

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address Univ. Hospital

(c) Hospital or institution: Redwood & Green St. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d.

(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State [illegible] (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1119 N. Stricker St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Betty Idell (Hall)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Thomas H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/1924

8. AGE: Years 20 | Months 9 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Warrenton, N.C. (Town, county, and state)

10. Usual Occupation Package wrapper

11. Industry or business American Sugar Ref. Co.

FATHER

12. Name John E. Jones

13. Birthplace N.C.

MOTHER

14. Maiden Name Mollie Williams

15. Birthplace N.C.

16 (a) Informant Cora Hunt (Sister)

(b) Address 234 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)

(c) Cemetery or crematory Warrenton Plain

Location Warrenton Plain, N.C.

18 (a) Funeral director Charles G. Cooper

(b) Address 512 N. Carrollton Ave

19 (a) ..... (Date rec'd by Reg.) APR 1 1945 Registrar

vs

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 19 45 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 19 45 to 4/16 19 45 and that I last saw h[illegible] alive on 4/16 19 45.

Immediate cause of death: Respiration + Cardiac + Failure — Duration

Due to: Overwhelming Toxemia

Due to: Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Patricia Dodd. M. D.

Address Univ. Hospital Date signed

X

G27983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G27983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1946 W North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15th

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 W North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard J. Bocklage

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1870

8. AGE: Years	Months	Days	If less than one day
74	5	24 23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Insurance salesman
11. Industry or business

FATHER
12. Name Henry Bocklage
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret McCarron
15. Birthplace Ireland

16 (a) Informant Henry Bocklage
(b) Address 1946 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Martin Tighe & Son
(b) Address 1827 W. North Ave.

19 (a) APR 17 1945 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19 at 6 P.M.

21. I certify that death occurred on the date above stated, that I last attended deceased from 4/16/45 19 to 4/16/45 19 and that I last saw h alive on 4/16/45 19

Immediate cause of death	Duration
(a) Cerebral Embolism	2 hrs
Due to (b) Coronary Occlusion	10 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Hourt M.D.
Address 1938 Mt Royal Ter Date signed 4/17/45 M. D.

VS 150

X

621984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

621984 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 McKean Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irma M. McKay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1911

8. AGE: Years 33 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John F. Belladarsch
13. Birthplace Austria

MOTHER
14. Maiden Name Caroline Meister
15. Birthplace Baltimore

16 (a) Informant Robert R. McKay
(b) Address 4702 York Rd.

17 (a) Burial (b) Date thereof 4/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Martin Zahn & Sons
(b) Address 1827 W. North Ave.

19 (a) Registrar

APR 17 1945

vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19 , at 12-15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11-45 to 4/16/45
and that I last saw h[illegible] alive on 4/16/45

Immediate cause of death
(a) Cerebral Embolism
Due to (b) Carcinoma of Uterus & Pulmonary Edema
Due to (c)
Other Conditions

Duration
(a) 3 hrs
(b) 1 yr.
(c)

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Stewart M.D.
Address Date signed 4/16/45

X

G27985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH #3a

G27985
Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st. St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto., Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Fearns)
Charles F. Macklin

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1 + 2	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emily Macklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace S. Dakota (Town, county, and state)
10. Usual Occupation Retired captain
11. Industry or business USN

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 18 1945 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Signature by registrar) (b) Registrar

APR 17 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to April 16 1945 and that I last saw him alive on April 16 1945

Immediate cause of death Massive right cere- | Duration
bral Hemorrhage due to | 5 hrs.

Due to Generalized arteriosclerosis | Unkn.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none done

Major findings of operation:

Massive right cerebral hemor-
of autopsy rhage due to generalised
arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
Address US Marine Hospital Baltimore, Md. Date signed 4/17/45

G27986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G27986 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3911 N. Charles Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Violet Mary Yakel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A. Yakel
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) April 15, 1860

8. AGE: Years	Months	Days	If less than one day
85	3	2	-- hr. --- min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Addison H. Brooks
13. Birthplace Michigan

MOTHER
14. Maiden Name Ellen Stage
15. Birthplace Michigan

16 (a) Informant Violet Clason Blake
(b) Address 630 Merrick Ave., Michigan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH 3911 N. 4/17 1945, at 1 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Apr. 17 1945, and that I last saw him alive on April 16 1945

Immediate cause of death Uremia — Duration 1 week
Due to Arteriosclerosis — 2 months
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert K. Mortimer Jr. M. D.
Address 2 E. Pleasant St Date signed 4/17/45

G27987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93A Registered No. G27987

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 43 N. Culver St.
(a) Baltimore City, Maryland
(b) Street address 43 N. Culver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 N. Culver St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Adolph Stoll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1860

8. AGE: Years 85 | Months | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Florist

11. Industry or business

FATHER 12. Name Adolph Stoll
13. Birthplace Baden Germany

MOTHER 14. Maiden Name Mary Louise Kellyman
15. Birthplace Baden Germany

16 (a) Informant J. C. Stoll
(b) Address 2830 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Dill Bros.
(b) Address 3107 Frederick Ave.

19 (Filed) APR 18 1945 (Registered) APR 18 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 45, at 1306 M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 19 45 to April 17 19 45, and that I last saw h[illegible] alive on April 16 19 45.

Immediate cause of death Myocardial Infarct

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Thomas

Address Mrs. Edwards Date signed 4/17/45

G27988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G27988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Wickelow st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baelimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Wickelow st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Wickelow

3 (a) **FULL NAME** Mary M Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Arthur P.

6 (c) If alive, give age 1873 years

7. Birth date of deceased (mo., day, yr.) Aug 2 1863

8. AGE: Years 71 | Months 8 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Sarh Stulling

13. Birthplace Md

MOTHER 14. Maiden Name Mary Schaub

15. Birthplace Md

16 (a) Informant James Reynolds

(b) Address 1803 Wickelow st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-45 (month) (day) (year)

(c) Cemetery or crematory Cedar Holy

Location Baltimore Md

18 (a) Funeral director Geye & Feeley

(b) Address Sutton & Fayette

19 (a) APR 18 1945 (Date rec'd by Registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19..., at ..... M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 1 1943 to April 16 1945 and that I last saw h.. alive on 4/15 1945

Immediate cause of death Cerebral Hemorrhage

Due to Femoral Arteriosclerosis & Hypertension

Due to .....

Other Conditions Cebral Hemorrhage (Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration: 4 days | 3 yrs | Aug 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Elliot W. Johnson

Address 3432 Fremont Ave Date signed 4/16/45 M. D.

VS 180

G27989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27989

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Jack Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Jack St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wm Leisure

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Martha Pauline Leisure
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1867

8. AGE: Years	Months	Days	If less than one day
77	8	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired R R Engineer
11. Industry or business B & O R R

FATHER
12. Name William H Leisure
13. Birthplace Maryland

MOTHER
14. Maiden Name S. Spurrer
15. Birthplace Maryland

16 (a) Informant Charles H Leisure
(b) Address 305 Jack Street (25 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18 45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling Milton Schilling
(b) Address 2914 S Hanover St - 25 Md

19 APR 18 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, at 11.30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1943 to April 15 1945, that I last saw him alive on April 14 1945.

Immediate cause of death: Acute Coronary Occlusion — Duration April 12-45

Due to Arterio-Sclerotic Cardio-Vascular Disease

Due to

Other Conditions Hypertrophy of Prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Leisure
Address 320 Chesapeake Ave Date signed 4/17/45
M. D.

X

G27990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. G27990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4025 Sixth Street-25 Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) xxx
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4025 Sixth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F Upton

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-1221

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ella M Upton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31 1873

8. AGE: Years 71 Months 5 Days 15 If less than one day hr. min.

9. Birthplace A A County Md
(Town, county, and state)

10. Usual Occupation Hardwood Floor Finisher

11. Industry or business Self

FATHER
12. Name Williham Upton
13. Birthplace A A County Md

MOTHER
14. Maiden Name Mary Rogers
15. Birthplace A A County Md

16 (a) Informant Mr Upton
(b) Address 4025 Sixth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3916 S Hanover Street

19 (a) APR 18 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to April 16 1945 and that I last saw him alive on April 16 1945

Immediate cause of death Carcinoma of stomach — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W Kreiter MD

Address 302 Professional Bldg Date signed 4/17/45

VS 180

G27991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157C

Registered No. G27991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2846 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Cutson / Cutson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W.	Female	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hr. 0 min.

9. Birthplace Mercy hosp. — Balt. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Cutson (Cuban)

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL APR 17 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 APR 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19..., and that I last saw h... alive on ... 19...

Immediate cause of death	Duration
Anencephalus	
Monster	
Due to Congenital Deformity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Turbett Jr. M. D.

Address Date signed

VS 130

2662 X

G27932 Drenga 209 S. Chester St 40 1994 G27992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 273 Dallas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 273 Dallas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond C. Whitehead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Fay Irene Whitehead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4th 1902

8. AGE: Years 43 | Months 1 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace De Soto, Missouri (Town, county, and state)

10. Usual Occupation Handyman - Bethlehem -

11. Industry or business Key Highway

FATHER
12. Name (Unknown) Whitehead
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Fay Irene Whitehead
(b) Address 273 Dallas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) ..... (b) ..... (Date received by Registrar)

APR 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 1945, at 1:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 17 1945 to April 17 1945 and that I last saw h~~im~~ alive on 4/17/1945

Immediate cause of death

	Duration
Coronary Occlusion	4/17/45
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Fr. Drenga

Address 209 S. Chester St Date signed 4/18/45

Huntington Williams, M.D.

Howard J. Meredith, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 627993

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fuenten Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson Fewster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband or wife Anne Fewster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1896

8. AGE: Years 48 | Months 5 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and State)

10. Usual Occupation Baseball player

11. Industry or business

FATHER 12. Name James Fewster

13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Fewster

15. Birthplace Ireland

16 (a) Informant Walter J. Fewster

(b) Address 1302 E. 33rd St.

17 (a) Burial (b) Date thereof 4/19/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ St. Johns Waverly

Location Balto Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) APR 18 1945
(Date rec'd by Registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/45 19... at 7.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1945 to April 16 1945, and that I last saw him alive on April 16 1945.

Immediate cause of death: Cardiac Failure — Duration

Due to: chronic myocarditis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Gaither M.D.

Address Mercy Hosp Date signed 4/18/45

27934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G27934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 Furrow st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Furrow st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Dorsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Carrie V. Dorsch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1870

8. AGE: Years 74 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Home Friendly Ins. Co.

FATHER 12. Name John Dorsch

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Schatz

15. Birthplace Germany

16 (a) Informant Mrs. Carrie V. Dorsch

(b) Address 215 Furrow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)

(c) Cemetery or ~~crematory~~ St. Johns

Location Howard Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) APR 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 1945, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to April 17 1945 and that I last saw h~~im~~er alive on April 16 1945

Immediate cause of death Uraemia Nephritis
Hypertension Cardiac Decomp
Arterio. Coronary Thrombosis

Duration

Due to

Due to Senility

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norbert C Nitsch M. D.

Address 2151 Wellington Date signed 4/17/45

VS 150

Wiles

627995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 627995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Wynderest Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK E WILES

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Madaline H. Wiles

6 (c) If alive, [illegible] 10/1895

7. Birthdate of deceased (mo., day, yr.) Sept. 21-1897

8. AGE: 47 Yrs | Months 6 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Ellicott City, Md (Town, county, and state)

10. Usual Occupation ? Civil Engineer

11. Industry or business

FATHER 12. Name Clarence Wiles

13. Birthplace Ellicott City, Md.

MOTHER 14. Maiden Name Martha Spurrier

15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Madaline Wiles

(b) Address 7 Wynderest ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof apr 18 1945 (month) (day) (year)

(c) Cemetery or crematory St. Johns Lane

Location Ellicott City, Md.

18 (a) Funeral director Easton Sons

(b) Address 608 Frederick ave. Catonsville

19 (a) Date received by Local Registrar 4-18-1945 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/45 19____, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner

Date signed 4/15/45

627996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

306

627996 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Joseph's Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27. S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Washington

3 (a) FULL NAME Ethel Hopkins (Ethel Hopkins)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Noah Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/09

8. AGE: Years 36 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Domestic work

11. Industry or business

FATHER
12. Name Joseph Bowie
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jeanette Sharp
15. Birthplace Balto. Md.

16 (a) Informant Crystal Chant
(b) Address St Joseph's Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Caroline St

19 (a) APR 18 1945 (Date rec'd by registrar) (b) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1945 to 4/16 1945, and that I last saw her alive on 4/16 1945.

Immediate cause of death Cardiac Failure — Duration

Due to Circulatory + Respiratory Failure

Due to

Other Conditions Enlarged Uterus Syphilis

(Include pregnancy within 3 months of death)

Date of operation 4/14/45

Major findings of operation: Enlarged Uterus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wakefield MD M.D.
Address St Joseph's Hosp Date signed 4/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR

VS 150

G27997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G27997

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 575 Laurens St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 575 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Sherwood (Alexander Nisbet)
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 5 1874
8. AGE: Years Approx 70 Months 11 Days 9 If less than one day hr. min.
9. Birthplace Oxford Md (Town, county, and state)
10. Usual Occupation Laborer (Unemployed)
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden Name Unknown.
15. Birthplace
16 (a) Informant Sarah E. Sprague
(b) Address 575 Laurens St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park Location
18 (a) Funeral director Robert L. Young
(b) Address 804 E. Caroline St.
19 (a) APR 18 1945 (Date rec'd by registrar) (b) Hunting for Williams M.T.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945 at 2 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to April 14 1945, and that I last saw him alive on April 13 1945.

Immediate cause of death Chronic Pancreatic abscess
Nephritis
Due to
Due to
Other Conditions Chronic Hypertension and Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

Duration
Sept 1944
Sept 1944

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ralph L. Young
Address 429 E. Monument St Date signed 4/16/45

VS 150

G27998 ✓ G27998

G27998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Main St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Schenck

3 (b) If veteran, name war —

3 (c) Social Security Account No. 207-14-0466

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31 1926

8. AGE: Years 18 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Stud Lab. Desk.

11. Industry or business

FATHER
12. Name Alfred Schenck
13. Birthplace Germany

MOTHER
14. Maiden Name Bessie Carnstein
15. Birthplace Balto Md.

16 (a) Informant Geo. E. Schenck
(b) Address 721 Main St. Reisterstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Ally D'Ainta
Location Reisterstown, Md

18 (a) Funeral director Wm. Berrymant Sons
(b) Address Reisterstown, Md

19 (a) (Date rec'd by registrar) APR 18 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1945, at 6:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1945 to 4/17 1945, and that I last saw h/m alive on 4/17 1945.

Immediate cause of death	Duration
Malignant Hypertension	
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Carl Myers M.D.
Address Franklin Sq. Hosp. Date signed 4/18/45

G27999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. 120417

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Easton + Wilkens

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2635 Wilkens ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mr. William Trainor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1897

8. AGE: Years	Months	Days	If less than one day
47	7	15	hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Police Dept.

11. Industry or business Baltimore Police Dept.

FATHER 12. Name Patrick Trainor

13. Birthplace Ireland

MOTHER 14. Maiden Name Ella F. Lynch

15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret A. Trainor

(b) Address 2635 Wilkens Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4309 Old Fred. Road

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar, M.D.

VS 150 APR 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/1945 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13/1945 to 4/16/1945 and that I last saw him alive on 4/16/1945.

Immediate cause of death	Duration
Cardio-Resp failure	
Due to Hemorrhage	
Due to Esophageal Varicies portal Cirrhosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Cliff Roth Jr. M. D.

Address St. Agnes Hosp Date signed 4/17/45

349673
G28000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G28000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 334 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Petty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred Petty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-13

8. AGE: Years 31 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Stage Builder Md

11. Industry or business Stage Hands

FATHER 12. Name Lenord C Petty

13. Birthplace Va.

MOTHER 14. Maiden Name Agnes Bottoms

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 18/45 (month) (day) (year)

(c) Cemetery or crematory

Location Roanoke Virginia

18 (a) Funeral director Mrs. Robert A Elliott & Dept

(b) Address 1129 N. Caroline St.

19 (a) APR 18 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16- 1945 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16- 1945 to 4-16 1945.
and that I last saw him alive on 4-16 1945.

Immediate cause of death Respiratory Failure — Duration

Due to ? Intracranial hemorrhage — 10 hrs.

Due to ? congenital aneurysm of circle of willis

Other Conditions Pulmonary edema, Pneumothorax, Left
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Benezra M. D.
Address Johns Hopkins Date signed 4-16-45

G28001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

G28001 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 W. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W. Hoffman St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Eliza Hare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1885

8. AGE: Years 59 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER 12. Name Thomas Robinson

13. Birthplace Virginia

MOTHER 14. Maiden Name Martha

15. Birthplace Virginia

16 (a) Informant Martha Highgrave

(b) Address 903 Morris St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) Date received APR 18 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1945, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to April 16 1945 and that I last saw h[illegible] alive on April 16 1945

Immediate cause of death	Duration
Cardio Vascular disease	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H. Watts M. D.

Address 515 Edmondson Ave. Date signed 4/16/45

VS 3

G28002 ✓ G28002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4507 Maine Ave. St., 94a Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 6 da. How long in U. S. If of foreign birth 32 yrs. mos. da.

2. FULL NAME Berel Machlis

If U. S. Veteran specify WAR

(a) Residence: No. 4507 Maine Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Lena Machlis

6. DATE OF BIRTH (month, day, year) Jan. 15, 1877

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68	67	3	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Furrier

10. Date deceased last worked at this occupation (month and year) 1926

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Berdichive Russia

FATHER

13. NAME Sam Machlis

14. BIRTHPLACE (city or town) (State or country) Russia

MOTHER

15. MAIDEN NAME Celia Siegel

16. BIRTHPLACE (city or town) (State or country) Russia

17. INFORMANT Lena Machlis
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Herring Run Date 4-18- 19 45

19. UNDERTAKER Jack Levy Inc
(Address) 1439 E. Baltimore St.

20. FILED APR 18 1945 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 17, 1945

22. I HEREBY CERTIFY, That I attended deceased from April 17, 1945 to April 17, 1945

I last saw him alive on April 17, 1945. Death is said to have occurred on the date stated above, at 3:45 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Coronary Thrombosis	4/17/45
Arteriosclerosis	?

Other contributory causes of importance:

Was an operation performed? no Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Clin. Data Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If specify

(Signed) L. Schlenger M. D.

(Address) 4600 Liberty Hgts Ave.

X

V. S. 3

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G28003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42D

G28003
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Physicians: please write the correct age in especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N Broadway & Fairmount
(b) Street address [redacted]
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Benjamin Shefferman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife wife deceased - Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	3	hr. min.

9. Birthplace [redacted] Russia
(Town, county, and state)

10. Usual Occupation Retired Tailor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Pt's Church Home & Hospital record)
(b) Address

17 (a) Burial (b) Date thereof 4-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Berea & Conkling St

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Balto St

19 (a) APR 18 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945 at 9:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1945 to 4-17 1945 and that I last saw h[illegible] alive on 4-17 1945

Immediate cause of death	Duration
Pneumonia Right Lung	11 days
Due to Total pneumonectomy - right	
Due to	
Other Conditions Post operative shock due to intrathoracic hemorrhage (Include pregnancy within 3 months of death)	13 days

Date of operation 4-7-45
Major findings of operation: Carcinoma of rt lung - pneumonia right
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James B. Brennan M. D.
Address Date signed 4-17-45

628004 ER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131

Registered No. 628004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1759 HOMESTEAD ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1759 HOMESTEAD. ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA ENGE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife C. OTTO. ENGE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB - 22 - 187 2

8. AGE: Years	Months	Days	If less than one day
73	1	26	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME.

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY.

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace GERMANY

16 (a) Informant MRS KATHERINE STRAKOSCH
(b) Address 1759 HOMESTEAD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-20-45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM
Location BALTIMORE MD

18 (a) Funeral director MRS CHAS A. GROHDE.
(b) Address 2327 EDMONDSON AVE
(c) (Date rec'd by Registrar) APR 18 1945 (Huntington-Williamsport, W. Va.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17 1945, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to April 16 1945, and that I last saw h[illegible] alive on April 16 1945

Immediate cause of death	Duration
(a) Terminal Pneumonia	
Due to (b) Chronic Myocarditis	
Due to (c) Chronic Nephritis	
Other Conditions Other Serious	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Seamon Bldg. Date signed 4/17/45

X

G28005

JO - 93081

BALTIMORE CITY HEALTH DEPARTMENT 46B ✓ G28005 Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 834 W. 34th St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ruhman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1856 ?

8. AGE: Years	Months	Days	If less than one day
88 ?	7 5 ?	10 ?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Ruhman

13. Birthplace Germany

MOTHER

14. Maiden Name Elizabeth Glaum

15. Birthplace Germany

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 45 (month) (day) (year)

(c) Cemetery or crematory Stars Chapel

Location Pikesville Md

18 (a) Funeral director Frank H. Purnell

(b) Address Pikesville, Md.

19 (a) APR 18 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945, to April 16 1945, and that I last saw h im alive on April 16 1945.

	Duration
Immediate cause of death Carcinoma of stomach with metastasis	3
Due to	
Due to	
Other Conditions Generalized arteriosclerosis	3

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H M Gallagher M. D.

Address Baltimore Md Date signed 4-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

628006 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6720 Roberts Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6720 Roberts Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lizzie (or) Stanislawa Dambrowski (or) Dombrowsky

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1886

8. AGE: Years 58 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation stove-keeper

11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Daniel Dambrowski
(b) Address 6720 Roberts Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Gorman Mill Rd.

18 (a) Funeral director Stephen J. Fialkowski
(b) Address 1010 S. Kenwood Ave.

19 APR 18 1945 Huntington Williams, MD
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1945, at 10:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1945, to April 15 1945, and that I last saw h alive on April 14 1945.

Immediate cause of death a Coronary Occlusion — Duration 0
Due to b Coronary Sclerosis — 1 yr.
Due to c — 1 yr.
Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Moore M. D.
Address 716 Cathedral Date signed 4-18-45

VS 180

G28007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto City
(b) Street address 117 Perry St
(c) Hospital or institution: ✓ 22 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Perry St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓

3 (a) FULL NAME William H. Matthews

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colrd | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 47 | Months — | Days — | If less than one day: hr. ✓ min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Paper Company

FATHER
12. Name Benjiman F. Matthews
13. Birthplace Howard County Md.

MOTHER
14. Maiden Name Ida Benson
15. Birthplace St Mary's County Md.

16 (a) Informant Worthington Matthews
(b) Address 1213 St Matthews St

17 (a) (Burial, cremation, or removal) (b) Date thereof 7 19 45
(month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore

18 (a) Funeral director Walter B. Briggs
(b) Address 139 W. Lanvale St.

19 (a) APR 18 1945 (Registrar) (b) Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17-1945, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12-1945, to 4-17-1945, and that I last saw him alive on 4-16-1945.

Immediate cause of death | Duration
Cerebral Hemmorhage | Unknown
Due to
Due to Hypertension
Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C Carson M. D.
Address 1016 E. Lanvale St Date signed 4-18-45

G28008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28008 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel White

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-1092

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or ~~wife~~ Bernard S. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1895

8. AGE: Years	Months	Days	If less than one day
50	2	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business Methodist Home

FATHER
12. Name Robert Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Coates
15. Birthplace Md.

16 (a) Informant Bernard S. White (Husband)
(b) Address 1524 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 18 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus, Balto. Co. Md.

18 (a) Funeral director John McJoynes
(b) Address 1700 Druid Hill Ave

19 (a) APR 18 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1945 at 9:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed 4-16-45

G28009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G28009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Greene Street
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Ruby Dicus

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Joseph C.

6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) May 1890

8. AGE: Years	Months	Days	If less than one day
54	11		hr. min.

9. Birthplace Chicago, Ill.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Ruby
13. Birthplace Ill.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Joseph C. Dicus
(b) Address 313 N. Green St.

17 (a) Cremation (b) Date thereof 4-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Government
Location Baltimore, Md.

18 (a) Funeral director Williams, Cook & Jones
(b) Address 1217 St. Paul St.

19 (APR 18 1945) Huntington for Williams, M.F.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-1945; at 6 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Spontaneous

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.....

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 4-17-45

G28010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G28010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 N. Gilmore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maynard Tubman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Annie Tubman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Annie Tubman
(b) Address 102 N. Madeira St.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Druid Park Lake Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 18 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944, to April 16 1945, and that I last saw him alive on April 16 1945.

Immediate cause of death Chronic interstitial nephritis — Duration Months / Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Godwin Schmelz M. D.
Address 1534 Druid Hill Ave Date signed April 17, 1945

G28011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1167 G28011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. I A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvia Childs Allen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife John Henry Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Clarence Childs
13. Birthplace N. C.

MOTHER
14. Maiden Name Rosie Carter
15. Birthplace Va

16 (a) Informant Louisiana Smith
(b) Address 1032 Hillen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave

19 (a) APR 8 1945 (Date rec'd by registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945, at 7 55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April at 14 1945 7 P M.
(b) Where did injury occur? 1200 Blk E. Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Stabbed

23. Signature Robert L. Gratton M.D. Medical Examiner.
Date signed April 15 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28012 / 108

Registered No. G28012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 Millington Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Millington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME John Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Littleton N. C. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy O. Wilson

18 (a) Funeral director
(b) Address 1200 Grant & Laurens Huntington Ave Milwaukee, Wis

19 1945 (Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1945, to 4/13 1945, and that I last saw h[illegible] alive on 4/13 1945.

Immediate cause of death — Duration

Cerebral Pneumonia — 4/7/45

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Calvin B LeCompte M. D.
Address 1613 4 Cowlings St Date signed 4/17/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28013

Registered No. 3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Etta L Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Seaboard, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Hady Barnes
13. Birthplace N. C.

MOTHER 14. Maiden Name Jessie Aderit
15. Birthplace N. C.

16 (a) Informant Etta L. Barnes
(b) Address 1025 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-45 (month) (day) (year)

(c) Cemetery or crematory
Location Seaboard, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) [illegible] Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16- 1945 at 4:20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxia by carbon monoxide (conflagration)

Due to

Other Conditions 4th degree burns hands 3rd degree burns face, scalp left buttocks (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 16/3

(a) Date of injury 4-16-45 4:20 P. M.
(b) Where did injury occur? 1608 Chalk alley
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Conflagration garage.

23. Signature [illegible] M.D. Medical Examiner.
Date signed April 17 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62801.4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lennon Dennis

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1901
8. AGE: Years: 44 Months: Days: If less than one day: hr. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Steam Captain
11. Industry or business

FATHER
12. Name: Joshua Dennis
13. Birthplace: Accomac, Va.

MOTHER
14. Maiden Name: Lucy Willis
15. Birthplace: Accomac Va.

16 (a) Informant: Lucy Willis
(b) Address: 1036 myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)
(c) Cemetery or crematory
Location: Accomac Va.

18 (a) Funeral director: Elroy A. Wilson
(b) Address: 1000 Brantley ave

19 (a) (Date received by registrar) (b) Registrar: [illegible]

APR 18 1945

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16/45 19 to 4/17/45 19, and that I last saw h/m alive on 4/17/45 19.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Carl Patterson, M.D.
Address: Mercy Hospital Date signed 4/18/45

X

G28015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

Registered No. G28015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3123 W. Ellerslie St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 W. Ellerslie St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ceman Hodges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Glenn L. Martin Co

FATHER
12. Name: Henry Hodges
13. Birthplace: Va.

MOTHER
14. Maiden Name: Martha Bryant
15. Birthplace: Va.

16 (a) Informant: Melvin Hodges (Brother)
(b) Address: Annapolis Rte 2, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory: Galax - Va
Location: Galax Va.

18 (a) Funeral director: Tilly & Zeile Sys
(b) Address: 1103 N. Wolfe St.

19 (a) APR 18 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1945 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Ruptured aneurysm - Circle of Willis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Madden M.D. Medical Examiner.
Date signed 4-18-45

Space #5

628016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

628016 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Street
(c) Hospital or institution: Fayette Harbor Pratt St + E. Falls Ave 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State / (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown Black Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY APR 17 1945
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 18 1945 (Date rec'd by registrar) (Signature) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945, at 10 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at 4/1 ? M.
(b) Where did injury occur? Harbor S. Falls Ave. Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found drowned

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 4-8-45

G28017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28017 Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/4 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 661 Portland (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY P. PAULONIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-0555

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Joseph PAULONIS
(b) Address 417 W Pratt St

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Apl 20 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kazmarzyk
(b) Address 617 Washington Blvd

19 (a) APR 18 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17/45 19 , at 5:33 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 4/17/45

G28018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G28018

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 W. Fayette St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Alyta

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 215-03-56[illegible]

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name George Alyta
13. Birthplace Lith ?

MOTHER
14. Maiden Name Agty
15. Birthplace Lith

16 (a) Informant Charles Alyta
(b) Address 714 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 20 – 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Cosmato
(b) Address 602 Washington Blvd

19 (a) APR 18 1945 (Date received by registrar) (b) Huntington Wilkins (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1945, at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry on the 18th and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature C. J. Lubrinski M.D.
Medical Examiner.
Date signed 4/18/45

VS 151

G28049 2386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G28019
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford.
(c) City or town Fallston
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W. Hawks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-44.

8. AGE: Years | Months: 6. | Days: 7 | If less than one day: hr. min.

9. Birthplace Fallston Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name Irvy Hawks
13. Birthplace Virginia

MOTHER
14. Maiden Name Eva King.
15. Birthplace North Carolina

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Zion
Location Bel Air Md.

18 (a) Funeral director Mezzy Fanning Sons.
(b) Address Baltimore Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

vs 1c APR 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH, April 17 1945, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945, to April 17 1945, and that I last saw him alive on April 17 1945.

Immediate cause of death	Duration
Asthmatic bronchitis	
Due to 2	
Due to bronchiolitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R Birmingham M. D.
Address JHH Date signed 4-18

G28020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G28020

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2092 Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Donaldson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Raymond

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-12

8. AGE: Years	Months	Days	If less than one day
32	7	27	hr. min.

9. Birthplace Mississippi (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Phillip Brow
13. Birthplace Louisiana

MOTHER
14. Maiden Name Estelle George
15. Birthplace Louisiana

16 (a) Informant Henrietta
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20 45 (month) (day) (year)

(c) Cemetery or crematory
Location Hagerstown, Md.

18 (a) Funeral director Fred W Ozazurek
(b) Address 1930 Eastern Ave.

19 (a) APR 18 1945 (Date rec'd by local reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 45 to April 17 1945 and that I last saw h. alive on April 17 1945

Immediate cause of death: Shock — Hemorrhage Due to post operative

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/12/45

Major findings of operation: Broad ligament tumor.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Chambers M.D.
Address 1 W Saratoga St Baltimore, Md. Date signed 4/18/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

G28021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G28021
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Waynesboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Park St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur J. Provard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Mrs. Wilbur J. Provard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1904

8. AGE: Years 40 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name John A. Provard
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Berth M. Summers
15. Birthplace Pennsylvania

16 (a) Informant Hosp. chart
(b) Address

17 (a) Removal (b) Date thereof 4/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Waynesboro Pa

18 (a) Funeral director Wm J. Trickett Home
(b) Address North & Pa Ave

APR 18 1945 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1945, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1945, to 4-18 1945, and that I last saw him alive on 4-18 1945.

Immediate cause of death: Cardio-Resp. failure — Duration

Due to Pulmonary embolus

Due to Exp. laparotomy for Carcinoma of rectum

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3-22-45
Major findings of operation Carcinoma of rectum & metastasis to bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morra, M.D.
M. D.
Address JHMH. Date signed 4/18/45

G28022

G28022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G28022

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Garrison Boul.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Garrison Boul.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Jacob Rice Pfeiffer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Estelle McC. Pfeiffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 31-1870

8. AGE: Years 74 | Months 3 | Days 17 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Commercial Refrigeration

11. Industry or business

FATHER
12. Name John Philip Pfeiffer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Ann Dunnigan
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Arthut Pfieffer
(b) Address 3817 Sequoia Ave.,

17 (a) Burial (b) Date thereof April 19-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Aves.,

19 (a) APR 18 1945 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 17 1945 at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Apr 17 1945, and that I last saw him alive on Apr 16 1945

Immediate cause of death Carsinoma Bronchogenic — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. H. Donald Jr. M. D.
Address 10 W. Madison St. Date signed Apr 17/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G28033

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amanda Yates

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife. John B. Yates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	5	21		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name William F. Horatio
13. Birthplace England

MOTHER
14. Maiden Name Bamber
15. Birthplace Va.

16 (a) Informant Mrs. Frederick Allen
(b) Address 1341 S. Charles St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 3 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto. Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) APR 18 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 19 45 at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bilateral Hypostatic Pneumonia

Due to

Other Conditions Fracture Hip left

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 4/2/45
(a) Date of injury 4/2/45 22/2 10:30 A.M.
(b) Where did injury occur? 1341 S. Charles St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Fall on Floor

23. Signature Dwight B. Caulkins Medical Examiner.
Date signed 4/18/45

X

G28024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28024 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 E. Fort Avenue (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Andrew Louis Holler

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 216-09-9739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Stella Holler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28 1882

8. AGE: Years	Months	Days	If less than one day
63	2	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerical
11. Industry or business Md D.D.

FATHER
12. Name Frederick Holler
13. Birthplace Md

MOTHER
14. Maiden Name Amelia Shubbard
15. Birthplace Md

16 (a) Informant Stella Holler
(b) Address 28 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto City

18 (a) Funeral director C. Howard Evans
(b) Address 1400 St Charles St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 APR 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1945 to April 16 1945, and that I last saw him alive on April 16, 1945.

Immediate cause of death	Duration
Circulatory Failure with massive hemorrhage	
Due to Gangrenous Intestine	
Due to Occlusion of Mesenteric vessels	
Other Conditions Infiltr. Lungs. (tbc)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Gangrene of distal port. jejunum, Adhesions
of autopsy of both lungs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmond Scarone M.D.
Address St. Joseph's Hosp. Date signed 4/16/45

X

4628425.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

G28025
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 6 WKS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County.....
(c) City or town Pittsburgh (If outside city or town limits, write RURAL and give town)
(d) Street No. 249 Richland Lane (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Katherine E. Beatty.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-99

8. AGE: Years	Months	Days	If less than one day
45	6	16	....hr. ....min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Gift Shop owner.
11. Industry or business

FATHER
12. Name John W. Beatty.
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah Hammett
15. Birthplace Pa

16 (a) Informant Friend.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 20-45 (month) (day) (year)
(c) Cemetery or crematory Pittsburgh.
Location Penna.

18 (a) Funeral director John D Mitchell
(b) Address 1900 Eutaw Pl.

19 (a) APR 18 1945 (Date rec'd by registrar) Huntington Willis (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18. 1945. at 12.22 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945. to April 18 1945. and that I last saw her alive on April 16 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature O.R. Langworthy M. D.
Address Johns Hopkins Hosp. Date signed 4/18/45

G28026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28026
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 HAMPNETT AV
(c) Hospital or institution: PINE RIDGE CONVALESCENT HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 WK
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO CO
(c) City or town ARBUTUS, #27
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 VOGT AV
(If rural give location)
(e) If foreign born, how long in U. S. A. ABOUT 50 years

3 (a) FULL NAME MARGARET GUNTNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife JOSEPH GUNTNER
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) MAY 30-1851

8. AGE: Years	Months	Days	If less than one day
93	10	17	....hr. ....min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name ANTHONY WURL
13. Birthplace GERMANY,

MOTHER
14. Maiden Name ANNA PFIRRER
15. Birthplace GERMANY

16 (a) Informant OTTO PFEILER (GRANDSON)
(b) Address 1932 POPLAR AV (ARBUTUS MD #27)

17 (a) BURIAL (b) Date thereof APR 19 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD CITY

18 (a) Funeral director JOHN R KENNY
(b) Address 343 LEEDS TER, ARBUTUS MD

APR 18 1945

19 (a) .....
(Date rec'd by registrar) Washington Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 17- 1945, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1945, to April 17 1945, and that I last saw h.. alive on April 17 1945

Immediate cause of death: Chronic myocarditis — Duration: .....
Due to: Degeneration
Due to: .....
Other Conditions: Chronic arthritis, Chronic Bronchial asthma
(Include pregnancy within 3 months of death)
Major findings:
Of operations: .....
Of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: .....
(b) Date of occurrence: .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury: .....

23. Signature W. V. Harlow, M. D.
Address 6716 Harford Road Date signed 4/18/45

X

G28027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56a

Registered No. G28027

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 North Chapel (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Cliffe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Cliffe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1870

8. AGE: Years 74 | Months 7 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business "

FATHER
12. Name James Holland
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Faunt
15. Birthplace Md.

16 (a) Informant Pt's Surbany
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) APR 19 1945 (b) Signature of local registrar for William Ryddings

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945 at 7 07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1945, to April 17 1945, and that I last saw h[illegible] alive on April 17 1945

Immediate cause of death Pulmonary atalectasis — Duration 4 days

Due to

Due to

Other Conditions Coronary Sclerosis with myocardial scarring. (Include pregnancy within 3 months of death)

Date of operation 4-9-45

Major findings of operation: Multiple Ovarian cysts

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Stevens Hatch, M. D.
Address Church Home Hospital Date signed 4-18-45

G28028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. G28028

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 38th & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo., 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co.
(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 E. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Ballard Preston Smith

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mrs. Roberta Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1897

8. **AGE:** Years 47 | Months 6 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Gas & Elec. Co.

FATHER
12. Name Ballard R. Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Jessie Keesee
15. Birthplace Virginia

16 (a) Informant Hosp. chart
(b) Address

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) ... (b) ... Registrar

APR 19 1945 Hunter for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1945, at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1945, to 4-18 1945, and that I last saw him alive on 4-18 1945.

Immediate cause of death Cardio respiratory failure — Duration

Due to Terminal laennec's cirrhosis

Due to

Other Conditions Thrombosis, diffuse

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Brigitte Nelson M. D.
Address Union Memorial Hosp. Date signed 4/18/45

G28023 G28023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution:
Home for Incurables - 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St
(If rural give location)
(e) Citizen of foreign country? no - (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Dealer Ney -

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George Phillips Ney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1864

8. AGE: Years	Months	Days	If less than one day
80	6	21	hr. min.

9. Birthplace Oakland, Garrett Co. Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name John Polster
13. Birthplace Europe

MOTHER 14. Maiden Name Margaret Remitz
15. Birthplace Europe

16 (a) Informant Mrs. Wm Ney
(b) Address 700 W 40th St.

17 (a) Burial (b) Date thereof April 19
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

APR 19 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1943 to April 16 1945, and that I last saw h-- alive on May 14 1945

Immediate cause of death: Congestive Heart Failure — Duration 3 weeks

Due to: Arteriosclerotic Cardio-Vascular Disease — Several years

Due to:

Other Conditions: Arthritis Deformans

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St. Date signed 4/16/45
Baltimore Md

G28030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28030 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Echodale Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Bohnet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31 1877

8. AGE: Years 67 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Deliverer

11. Industry or business

FATHER 12. Name Adam Bohnet

13. Birthplace Md.

MOTHER 14. Maiden Name Katheryn Houck

15. Birthplace Md

16 (a) Informant Mildred Glaerker

(b) Address 3202 Echodale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 E Orleans St

19 (a) APR 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1945, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1945 to 4/18 1945, and that I last saw h[illegible] alive on 4/18 1945.

Immediate cause of death Cerebro-vascular accident — Duration

Due to

Due to

Other Conditions Hypertension & V disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers, M.D.

Address Franklin Sq. Hosp. Date signed 4/19/45

G28031 / G28031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 McKean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Lasover

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53yr			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Paperhanger
11. Industry or business Jobbing

FATHER
12. Name Isadore Lasover
13. Birthplace Russia

MOTHER
14. Maiden Name Nettie Kussen
15. Birthplace Russia

16 (a) Informant Ethel Lasover
(b) Address 1618 McKean Ave

17 (a) Burial, cremation, or removal Interment (b) Date thereof 4-19-45 (month) (day) (year)
(c) Cemetery or crematory Wyndham Circle
Location Hebrew Mt. Carmel
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St
19 (a) APR 19 1945 Registrar
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 18 1945 at 2 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 19 to 19
and that I last saw h[illegible] alive on Apr 18 19 45
Immediate cause of death Cardiac decompensation
Due to Coronary occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Apr 12-45
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Melvin Armbrecht
Address Date signed 4/19/45 M. D.

G280332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G280332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 S. Caroline St
(c) Hospital or institution: 3'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lettie Beatrice Clark Jones Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Robert Johnson
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1886

8. AGE: Years	Months	Days	If less than one day
60	2	12	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Adele McCoy
(b) Address 417 S. Caroline st

17 (a) Burial (b) Date thereof 4/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Richmond, Va.

18 (a) Funeral director Ebroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams

APR 19 1945

VS 150

MEDICAL CERTIFICATION 11:20 PM

20. DATE OF DEATH 4/15 1945 at 11.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1945 to 4/15 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral hemorrhage	1 hr.
Due to Hypertensive cardio-renal disease	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 E. Madison St Date signed 4/18

Rayner Browne X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628033

JO #93171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

628033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Carlton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1927

8. AGE: Years	Months	Days	If less than one day
18	-2-	21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Boone
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) APR 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1945, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:25PM 4-17 1945 to 7:30PM 4-17 1945, and that I last saw h... alive on 4-17-45 1945

Immediate cause of death: Cardiac failure ?

Duration: 2

Due to: Miliary Tuberculosis?

Due to:

Other Conditions: Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sauel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 4-18-45

VS 180 SUBJECT TO APPROVAL OF MEDICAL EXAMINER: Ext. B.C.J. Entered Howard J. Madden, M.D.

G28034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G28034 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3239 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3239 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Verna Marie Pantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1890

8. AGE: Years	Months	Days	If less than one day
55	-	14	hr. min.

9. Birthplace Kansas (Town, county, and state)

10. Usual Occupation

11. Industry or business Methodist Pub. House

FATHER 12. Name August R. Pantz

13. Birthplace Wisconsin

MOTHER 14. Maiden Name Jeanette Donaldson

15. Birthplace Mo

16 (a) Informant Miss Gladys Pantz

(b) Address 605 Cathedral St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/19/45 (month) (day) (year)

(c) Cemetery or crematory Abilene

Location Abilene Kansas

18 (a) Funeral director Harry A. Wiltse

(b) Address 401 Edmondson Ave.

19 (a) APR 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 17 1945, and that I last saw h[illegible] alive on April 7 1945.

Immediate cause of death: Chronic salpingitis

Due to: Lead disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emmett D. Rabin

Address 173 E Page Ave Ft Date signed 4/18/45

Huntington Williams M.D

VS 150

G28045 471703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G28045 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Blythe

3 (b) If veteran, name war

3 (c) Social Security Account No. 165-09-9392

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Dorothy Schammel
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 11-18-81

8. AGE: Years	Months	Days	If less than one day
63	7	-	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Mach. Ship Inspector
11. Industry or business Glen L. Martin

FATHER
12. Name Blythe
13. Birthplace ? ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave & Milton st

18 (a) Funeral director Harry A Whitaker
(b) Address 4101 Edmondson Ave

19 (a) APR 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1945, to April 18 1945, and that I last saw him alive on April 18 1945.

Immediate cause of death: Respiratory Failure — Duration
Due to: Lymphosarcoma of Mediastinum & Lungs
Due to:
Other Conditions: Hydrothorax Bilateral
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date 4/18/45

Huntington Williams, M.D.

VS 150

G28036

JO #92992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135

Registered No. G28036

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 859 N. Fremont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Fred Douglas Poisson

3 (b) If veteran, name war: —

3 (c) Social Security Account No. 213-05-8949

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Poisson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1901

8. AGE: Years 45 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business Camp Holabird

FATHER
12. Name Fred Poisson (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Emma ?
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) APR 18 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1945, at 7:46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 7, 1945 to Apr. 17, 1945 and that I last saw h. im alive on Apr. 17, 1945.

Immediate cause of death: Pulmonary tuberculosis — Duration (a) 1 mo

Due to

Due to

Other Conditions: Diabetes mellitus, Thrombophlebitis d.t. femoral & ile
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold J. Dillon M. D.
Address Balt City Hosp. Date signed 4/18/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

628037 628037 628037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 92D

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 2560 Woodbrook St. [redacted] Ward)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Holly 3
(a) Residence: No. 2560 Woodbrook St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

If U.S. Veteran specify WAR .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single [illegible]

3a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Aug 1889

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER
13. NAME [illegible]
14. BIRTHPLACE (city or town) (State or country) Md

MOTHER
15. MAIDEN NAME Rosie —
16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Elizabeth Holliday
(Address) 2560 Woodbrook Lane

18. BURIAL, CREMATION, OR REMOVAL
Place St Peters Date 4/21/45

19. UNDERTAKER Geo. A. Nelson
(Address) 1383 Pleasant St.

20. FILED APR 19 1945 Huntington Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 18, 1945

I HEREBY CERTIFY, That I attended deceased from March 6 1945 to April 18 1945

I last saw her alive on April 17 1945 Death is said to have occurred on the date stated above, at 7.15 a.m. AM

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Disease	
Heart	

Other contributory causes of importance:

Was an operation performed? — Date of —

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so specify

(Signed) Hawk E. Magruder M.D.
(Address) 3027 Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

(3)

G28038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G28038 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address Freeland Redwood
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 660 West Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucille WATSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1919

8. AGE: Years 25 | Months 7 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Richmond, Virginia (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Dennis W[illegible]
13. Birthplace North Carolina

MOTHER
14. Maiden Name Daisy Curran
15. Birthplace North Carolina

16 (a) Informant Mrs. Lodie Watson

(b) Address 660 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-'45 (month) (day) (year)

(c) Cemetery or crematory

Location Richmond, Va

18 (a) Funeral director Mrs Hattie R. Wilkins

(b) Address 322 N. Lafayette

19 (a) APR 19 1945 (Date rec'd by local reg.) (b) Huntington Nelhaven Va Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17/45 19..... at 12:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner

Date signed 4/17/45

628039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 628039

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway & Fairmount
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3937 Frisby St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph V. O'Connor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Margaret Murray O'Connor
wife deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1863

8. AGE: Years	Months	Days	If less than one day
81	6	25	hr. min.

9. Birthplace Baltimore Maryland
Balt. Co. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Murray
15. Birthplace Maryland

16 (a) Informant Hospital History
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 9242 Eager St. Baltimore Md.

19 (a) (Date filed) (b) Written from records of Williams, M.D.
Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 1945, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1945, to 4-18 1945, and that I last saw him alive on 4-18 1945.

	Duration
Immediate cause of death Pneumonia	16 days
Due to Generalized Carcinomatosis	2 yrs.
Due to Carcinoma descending Colon.	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-9-45
Major findings of operations: Generalized Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrance at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Stevens Hatch M. D.
Address C. H. H. Date signed 4-18-45

G28040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G28040

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Payne + Dukeland Sts

(c) Hospital or institution West Balt. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County 1

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3504 Fairview Ave. (if rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** AMON Brian GREEN

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M Married

6 (b) Name of husband or wife Lillian Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/17/1881

8. AGE: Years	Months	Days	If less than one day
63	10	21	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name James T. Green

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Emma Brian

15. Birthplace Balto. Md.

16 (a) Informant Lillian Ford Green

(b) Address 3504 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount Ave. + 31st St

18 (a) Funeral director John Mitchell Hoss

(b) Address 1900 Eutaw Place

19 (a) APR 19 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/45 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1945 to 4/18 1945.

and that I last saw h[illegible] alive on 4/18 1945.

Immediate cause of death URAEMIA and AC1005IS — Duration

Due to CHRONIC ARTERIO SCLEROTIC NEPHRITIS

Due to

Other Conditions MODERATE CONGESTIVE HEART FAILURE (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. M. Ehrenfeld M. D.

Address West Balt Gen Hosp Date signed 4/19/45

VS 150

17 G28041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28041 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma H Mechem

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months — | Days — | If less than one day hr. min.

9. Birthplace Fort Worth Texas
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired School Teacher

FATHER 12. Name Abel Frank
13. Birthplace Maryland

MOTHER 14. Maiden Name Susan Hazeltine
15. Birthplace Cal Kennard

16 (a) Informant Mrs James Finby
(b) Address 312 E Lyndin Ave

17 (a) Burial Lindenwood (b) Date thereof 4-20-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Linden Park Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E. 32nd St

19 (a) APR 19 1945 Hunting Park, Philadelphia, Pa.
(Date received by local registrar) (Registration district)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1945; at 11:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1933 to 4/17 1945, and that I last saw her alive on 4/16 1945.

Immediate cause of death: Myocarditis Arterio Sclerosis — Duration: Several

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M F Moody M. D.
Address 1402 Park Ave Date signed 4/19/45

X

G28042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45

Registered No. G28042

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wenheim & Linden
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Chapel Gate Lane #29 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Emma Hotson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3 1868

8. AGE: Years	Months	Days	If less than one day
77	2	15	hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Edward D. Chapin
13. Birthplace N. Hampshire

MOTHER
14. Maiden Name Olive S Stanford
15. Birthplace Maine

16 (a) Informant John Hotson
(b) Address 703 Chapel Gate Lane.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/2/45 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Brooklyn, New York.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 East Madison Street

19 (a) APR 19 1945 (Date received by local registrar) (b) Interring for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1945, to 4/18 1945; and that I last saw her alive on 4/18 1945

Immediate cause of death Coma

Due to Carcinoma of Sigmoid + Obstruction

Due to 5 days after colostomy + 2 days after opening of colostomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/13/45 & 4/16/45

Major findings of operation: Ca of Sigmoid

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. W. Grayson M. D.
Address Md. Gen. Hosp. Date signed 4/18/45

G28043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G28043
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Stevenson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Julius Hamill

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-06-8762

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1902

8. AGE: Years 42 | Months 8 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O RR

FATHER
12. Name James Hamill
13. Birthplace Md

MOTHER
14. Maiden Name Mary Mitchell
15. Birthplace Md.

16 (a) Informant Mrs. Frances Hamill
(b) Address 1422 Stevenson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location B. G. Co.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

APR 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to April 17 1945, and that I last saw him alive on April 16 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Decompensated Heart	
Due to Rheumatic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address U.M.H. Date signed 4-17-45

G28044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G28044 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colmt Saratoga Sts.
(c) Hospital or institution: Mercy Hospital. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Colmt~~ 1308-E-33rd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F. Powell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mrs. Clara Powell

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb-18-1864

8. AGE: Years 81 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Syracuse ~~New York~~ N.Y.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Jackson
15. Birthplace —

16 (a) Informant Mrs. Clara Powell
(b) Address 1308-E-33rd St.

17 (a) Burial (b) Date thereof 4-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Leonard J. Rust
(b) Address 1305 Hanford St.

APR 19 1945

19 (a) [illegible] Washington Wilmette, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to 4/17 1945, and that I last saw h. ~~was~~ alive on 4/17 1945.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic C.V.D.

Due to —

Other Conditions Cerebral accident monoplegia upper ext.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry F. Rolfes M.D.

Address Mercy Hospital Date signed [redacted]

X

G28015 D 23718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G28015 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: St Josephs Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 W Lafayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Talley.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Infant (Premature)

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/45

8. AGE: Years | Months | Days | If less than one day hr. min.
3 mo. 5 mos

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sterling Talley.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Jamie Hill
15. Birthplace Baltimore Md

16 (a) Informant Chart
(b) Address Hospital.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltz-

18 (a) Funeral director Leonard A Seibert
(b) Address Baltimore Md

19 (a) APR 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1945, at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1945 to 4/16 1945; and that I last saw her alive on 4/16 1945

Immediate cause of death Cardiac failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan E Schwartz M.D.
Address St Josephs Hosp Date signed 4/16/45

VS 150

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28046 — CERTIFICATE OF DEATH — √112 G28046

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 Brighton St., 16-7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Elsie Ferguson Rodgers — If U. S. Veteran specify WAR

(a) Residence: No. 3032 Brighton St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	W

6a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: George H. Rodgers

6. DATE OF BIRTH (month, day, year): 9/29/81

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	6	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Balto. Md.

FATHER

13. NAME: Samuel T. Ferguson

14. BIRTHPLACE (city or town) (State or country): Wash., D. C.

MOTHER

15. MAIDEN NAME: Emma Cromwell

16. BIRTHPLACE (city or town) (State or country): Balto. County Md.

17. INFORMANT: S. Proctor Rodgers
(Address): 303 Wendover Rd.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
Place: Greenmount Cem. Date: 4/21/45 19

19. UNDERTAKER: John D. Mitchell & Sons, Inc.
(Address): 1900 Eutaw Place

20. FILED ... 19... ... Registrar.

APR 19 1945 — Huntington Mitchell, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): April 18, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 1935 to April 18 1945

I last saw h[illegible] alive on Jan 5 1945. Death is said to have occurred on the date stated above, at 7.30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocardial failure	1 day
due to Bronchial asthma	15 yrs.

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Vernon H. Norwood M.D.

(Address) Church Home & Hospital

V8 8

X

G26047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G26047 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 N. Spring St.
(c) Hospital or institution: 717 N
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N Spring St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Sunny) Sonny Shanks

3 (b) If veteran, name war: 1 Yes
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband ~~or wife~~ Hattie Shanks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1903

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Saloon
11. Industry or business

FATHER
12. Name Monphus Shanks
13. Birthplace NC

MOTHER
14. Maiden Name Eliza Downey
15. Birthplace Va

16 (a) Informant Hattie Shanks
(b) Address 717 N Spring St

17 (a) Burial (b) Date thereof (Burial, cremation, or removal) Apr 20 1945 (Month) (Day) (Year)
(c) Cemetery or crematory Mt Calvary Cem
Location A & Co Rds

18 (a) Funeral director Robert E Gilliam
(b) Address 1515 W Lexington St

19 (a) APR 19 1945 Huntington Williams
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema,
Hypertensive Cardiovascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 16 1945

VS 151

G26048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G2804-8 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 45 S. Stockton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits write RURAL and name town)
(d) Street No. 45 S Stockton St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Samuel Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-2755

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Flossie Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Seton
11. Industry or business

FATHER 12. Name Jack Barnes
13. Birthplace

MOTHER 14. Maiden Name Eliza Taylor
15. Birthplace N C

16 (a) Informant Flossie Barnes
(b) Address 45 S. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) APR 20 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 18 1945, and that I last saw h alive on April 14 1945

Immediate cause of death	Duration
Gastric Carcinoma	
Due to	
Due to	
Other Conditions Hematemesis	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Hans Kobrunner M.D.
M. D.
Address 1715 W Pratt Date signed 4/19/45

VS 150

Huntington Williams, M.D.

#3

628049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

628049 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6705 Graceland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N/A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6705 Graceland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE J. STANISWSKI or Dominis

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 213-07-7851

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Aline Croxton
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1898

8. AGE: Years 46 | Months 8 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Shipper

11. Industry or business Bethlehem Steel Corp.

FATHER
12. Name Peter Staniewski
13. Birthplace Poland.

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Aline Staniewski
(b) Address 6705 Graceland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Fratkowski
(b) Address 1000 S. Kenwood Ave.

19 (a) APR 19 1945 (Undertaker's registration) Huntington Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/45 19..., at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 4/19/45

G28050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G28050 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3037 Woodland ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Woodland ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Clinton Sipes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Sarah E. Sipes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	17 16	hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joshua Sipes
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Colley
15. Birthplace Baltimore County Md.

16 (a) Informant Anna Seiber
(b) Address 3037 Woodland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19 - 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Randallstown Maryland

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Maryland

19 (a) APR 19 1945 (Date) Huntington Williams (By whom registered)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1945 to April 16 1945 and that I last saw h[illegible] alive on April 16 1945

Immediate cause of death
Pulmonary Embolism
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee J. Volenick M. D.
Address 9710 Liberty Rd Date signed 9/13/45

Lee J. Volenick

G28051
JL - 92916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28051
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Cora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1877

8. AGE: Years	Months	Days	If less than one day
68	0	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Sharp
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto Md

18 (a) Funeral director Wm Ignatius J. Williams
(b) Address 212 Schroeder St

19 (a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

APR 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1945, at 6:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1945 to April 15 1945 and that I last saw him alive on April 15 1945

	Duration
Immediate cause of death Cardiac failure	
Due to Arteriosclerotic heart disease	7
Due to Myocarditis - pulmonary	
Due to infarcts	?
Other Conditions Syphilitic aortitis	
Bilateral Pyelonephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Cause

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 4-16-45

G280352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G280352

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy S. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-8068

4. Sex: M.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna J. Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1890

8. AGE: Years 54 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace: Pa
(Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Gov. Yard & Scale

FATHER
12. Name: John Smith
13. Birthplace: Pa

MOTHER
14. Maiden Name: Mary Smith
15. Birthplace: Md

16 (a) Informant: Mrs R. S. Smith
(b) Address: 109 N. 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Taylor Ave

18 (a) Funeral director: J. J. Fahey & Sons
(b) Address: 310 Light St.

19 (a) APR 19 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to April 18 1945, and that I last saw him alive on 4/18 1945

Immediate cause of death: Hypertensive cardio-vascular disease — Duration: 2 yrs

Due to:

Due to:

Other Conditions: Acute uremia — 1 day

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Benjamin Mullan M. D.

Address 2030 Wilkens Date signed 4/18/45

above X

628053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 628053

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 E. Clement
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 E Clement St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard C. Gehring

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-9439

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillian Haas

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Sept 13 1892

8. AGE: Years 52 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Shipping Dept.

11. Industry or business Manufacturing Stevedore

FATHER — 12. Name John Gehring

13. Birthplace Baltimore

MOTHER — 14. Maiden Name Mary Bauer

15. Birthplace Baltimore

16 (a) Informant Mrs L. M. Gehring

(b) Address 635 E Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway adco

18 (a) Funeral director J. Edgar Long

(b) Address 1318 Light St.

19 (a) APR 19 1945 (Date received by registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945 at 6. P. M

21. I certify that death occurred on the date above stated, that I attended deceased from April 15 1945 to April 17 1945 and that I last saw him alive on April 17 1945.

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions Arteriosclerosis & Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Schemmel

Address 1337 S Charles St Date signed 4/18/45

G28054
JL - 92721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G28054

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly written. Physicians: please write the causes of death clearly and legibly. The age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lacy Black

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ? 1908

8. AGE: Years	Months	Days	If less than one day
37 ?	/ ?	?	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hugh
13. Birthplace N. C.

MOTHER
14. Maiden Name Hannah Wilkerson
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 4 20 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burial
Location Loudon Park

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Eastern Ave.

19 Apr 20 1945 Hunter for Williams M.E.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 17, 1945 19 , at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1945 to April 17 1945, and that I last saw him alive on April 17 1945

Immediate cause of death	Duration
Pulmonary Hemorrhage	minutes
Due to Pulmonary Tuberculosis	(?)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Maryland Date signed 4/19/45 M. D.

X DALMAU

VS 150

G28055

34979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

Registered No. G28055

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Ivorwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Champe P. Terry

3 (b) If veteran, name war V | 3 (c) Social Security Account No. V

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-69

8. AGE: Years 75 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Col. Wm. P. Pryde
13. Birthplace Virginia

MOTHER 14. Maiden Name Margaret Walker
15. Birthplace Virginia

16 (a) Informant Pedrop
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20 (month) (day) 45 (year)
(c) Cemetery or crematory Greenmount Cem.
Location Lynchburg Va.

18 (a) Funeral director John Oppatelli & Sons
(b) Address 1200 Eutaw Place

19 (a) APR 20 1945 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to April 19 1945; and that I last saw h[illegible] alive on April 19 1945

Immediate cause of death	Duration
Myocardial failure	6 mos
Due to Hypertensive cardio vascular disease	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 8 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D.B. King M. D.
Address J. Hopkins Hosp. Date signed 4-19-45

X

M. D. B. 1268-a

28056

HEALTH DEPARTMENT—CITY OF BALTIMORE

28056

CERTIFICATE OF DEATH 92 D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 St. James St., 10 Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 67 yrs. 10 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Benson Kelly

(a) Residence: No. 1216 St. James St., 10 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M.	Col.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) March 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	1		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Belton Charles Maryland

FATHER

13. NAME Charles S. Kelly

14. BIRTHPLACE (city or town) (State or country) Belton Charles Md

MOTHER

15. MAIDEN NAME Mary Swan

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Sarah Giles

(Address) 417 Heaver St.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Calvary Cem. Date April 20 1945

19. UNDERTAKER Wm Walter R. Williams

(Address) 322 N Schroeder St.

20. FILED APR 20 1945 19.....

Walter R. Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4-17- 45

22. I HEREBY CERTIFY, That I attended deceased from 3/15 1945 to 4-17- 1945

I last saw h alive on 4- 17 1945 Death is said to have occurred on the date stated above, at 5:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Duration
Bronchopneumonia	2 days
Edema (Indefinite period)	
Endocarditis (Indefinite period)	

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Just P Blake M.D.

(Address) 1327 N. Central Ave Baltimore Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G28057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G28057

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Carrollton ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Carrollton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Lindow Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 - 1944

8. AGE: Years | Months: 9 | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Turner
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Bernadine Littlefield
15. Birthplace Baltimore, Maryland

16 (a) Informant Bernadine Turner
(b) Address 119 N. Carrollton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 322 N. Schroeder St.

APR 20 1945

19 (a) (Date rec'd by registrar) Huntington Williams (Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1945, to April 17 1945, and that I last saw him alive on April 16 1945

Immediate cause of death: Broncho pneumonia — Duration: 5 days

Due to

Due to

Other Conditions: acute Bronchitis — Duration: 3 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. D. Julian Jr. M.D.

Address 711 N. Schroeder St. Date signed 4/18/45

G28058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G28058

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin M. Keyser

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-5319

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Lottie L. Keyser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23rd 1889

8. AGE: Years	Months	Days	If less than one day
55	5	26	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry Bethlehem Ship Building Co

FATHER
12. Name James M. Keyser
13. Birthplace Va.

MOTHER
14. Maiden Name Addie A. Brown
15. Birthplace Va.

16 (a) Informant Mrs. Lottie L. Keyser
(b) Address 1733 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul Huntington Williams, Mgr

19 (a) (b)
Date received by Registrar — Registrar

APR 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1945, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1945 to 4-19 1945 and that I last saw him alive on 4-19 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Bronchial Pneumonia	
Due to	
Other Conditions Diabetes, Hypertrophic arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Joseph Hosp. Date signed 4-19-45

107

G28059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28059

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Walnut Ave-Regnal Hgts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Remley st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Potts

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: William F. Potts
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 14 th 1864

8. AGE: Years	Months	Days	If less than one day
81	2	5	hr. min.

9. Birthplace Pa
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Enoch Kelbaugh
13. Birthplace Pa.

MOTHER
14. Maiden Name Ann Jones
15. Birthplace Unknown

16 (a) Informant Viola Grimore
(b) Address 3318 Remley St.

17 (a) Burial (b) Date thereof 4/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) APR 20 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1945, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945, to April 19 1945, and that I last saw her alive on April 19 1945.

Immediate cause of death	Duration
Edema of lungs	8 hrs.
Due to Cerebral Hemorrhage	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Wells. M. D.
Address 4100 Edmondson Ave Date signed 4/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G28060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 Henry st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John a. Dowling

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Isabelle M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th about 1882

8. AGE: Years: about 62 | Months: 11 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Balto. Md (Town, county, and state)
10. Usual Occupation: Building Inspector
11. Industry or business: City of Balto

FATHER
12. Name: Thomas Dowling
13. Birthplace: Un Known

MOTHER
14. Maiden Name: Mary Allen
15. Birthplace: "

16 (a) Informant: Isabelle Dowling
(b) Address: 1516 Henry St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery ~~mausoleum~~ Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

19 (a) APR 20 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th 1945, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to 4/18/ 1945, and that I last saw h~~im~~ alive on 4/07/1945.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to arteriosclerosis	1 year
Due to Chronic Coronary attacks	8 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Mullé M. D.
Address 1125 N. Charles Date signed 4/18/45

VS 150

G28061(4) File

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G28061

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline Street
(c) Hospital or institution:
St. Josephs Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 N Caroline treet
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Barnes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Taylor
13. Birthplace D.C.

MOTHER
14. Maiden Name Delia —
15. Birthplace D.C.

16 (a) Informant Albert Scott
(b) Address 923 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James Atkins
(b) Address 142 W. Hoch St

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

APR 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 4:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1945 to 4/19 1945. and that I last saw her alive on 4/19 1945.

Immediate cause of death	Duration
Hypertensive cardio-vascular renal disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Culley M.D.
Address Mt. Zion Hospital Date signed 4-19-45

628062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

628062
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town TOWSON
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 DELAWARE AVE
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME STUART KIMBLE WOODWARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife VIOLET WOODWARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/26/11

8. AGE: Years	Months	Days	If less than one day
33	11 10	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Eastern Aircraft Co.

FATHER
12. Name SAMUEL K WOODWARD
13. Birthplace PENN.

MOTHER
14. Maiden Name RUTH JACKSON
15. Birthplace MD.

16 (a) Informant Mrs. Violet Woodward
(b) Address Towson, Md.

17 (a) Burial (b) Date thereof April 21 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

APR 20 1945 (b) Huntington Williams M.E.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 18 1945, at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 9 1945, to 4-18 1945, and that I last saw him alive on 4 - 18 1945.

Immediate cause of death	Duration
ATYPICAL PNEUMONIA	
Due to POST OPERATIVE ATELECTASIS	
Due to	
Other Conditions RUPTURED GANGRENOUS APPENDIX, PERITONITIS, ADYNAMIC ILEUS (Include pregnancy within 3 months of death)	

Date of operation 4/7/45

Major findings of operation: RUPTURED GANGRENOUS APPENDIX, PERITONITIS

of autopsy: PARTIAL INTEST. OBSTRUCTION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Traynor M. D.
Address Md. General Hosp. Date signed 4/17/45

G28063

472325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28063

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glen Arm
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Hannibal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-5-45

8. AGE: Years	Months	Days	If less than one day
—	—	13	— hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Babe

11. Industry or business

FATHER 12. Name William Irvin Hannibal

13. Birthplace Md

MOTHER 14. Maiden Name Ruth Mae Biggs Hannibal

15. Birthplace Baltimore, Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof April 20 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Md.

18 (a) Funeral director John Burns & Sons
(b) Address Towson, Md.

19 APR 20 1945 (b) Huntington Ave Baltimore Md.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 8 a.m. p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945, to April 18 1945, and that I last saw him alive on April 16 1945

Immediate cause of death Cardiac failure — Duration

Due to Pneumonia & Pericarditis — 3 days

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas B. Nejjas M. D.

Address Johns Hopkins Hosp. Date signed 4-19-45

X

628064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. 628064

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville - 28 Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 Melvin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19-45

8. AGE: Years	Months	Days	If less than one day
			7 hr. 5 35 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Crane Johnson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dorothy Marie Bohon
15. Birthplace Baltimore - Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof April 20 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director Elizabeth Hart Fun
(b) Address 115 E. West St.

19 (a) APR 20 1945 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19-1945 at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19-1945 to 4-19-1945 and that I last saw h.er alive on 4-18-1945.

Immediate cause of death Atelectasis

Due to Prematurity

Due to Premature Delivery

Placenta.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Rogers M. D.
Address Bon Secours Hosp Date signed 4-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

740 ✓

Registered No. G28065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 Da
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franka, Frank — FRANK FRASCA

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	213-07-6360

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of ~~XXXXX~~ or wife Rachela Frasca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25 1889

8. AGE: Years	Months	Days	If less than one day
56	1	24	hr. min.

9. Birthplace Veruli Roma Italy
(Town, county, and state)

10. Usual Occupation Forman
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Pasquale Frasca
13. Birthplace Italy

MOTHER
14. Maiden Name Cecilia Colella
15. Birthplace Italy

16 (a) Informant Rachela Frasca (Wife)
(b) Address 1320 Eastern Ave

17 (a) Burial (b) Date thereof April 21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer CeM.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Wells Sons
(b) Address 1925 Morley St.

19 (a) APR 20 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 1945, at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1945 to 4-18 1945, and that I last saw him alive on 4-18 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Lymphatic Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St. Josephs Hosp Date signed 4-18-45

VS 199

X

628066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 628066

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Granby Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio or Tony Alvino Alvino

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-05-3143

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Jennie Alvino

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1899

8. AGE: Years 45 ~~46~~ | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Avellino Italy
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Fabiano Alvino
13. Birthplace Italy

MOTHER
14. Maiden Name Antonietta Gesu
15. Birthplace Italy

16 (a) Informant Jennie Alvino (Wife)
(b) Address 907 Granby St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

APR 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 45 - 12:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-19-45 at 12:30 P. M. 2b6
(b) Where did injury occur? (BALTIMORE COPPER WORKS) Smelting & Refining Co. Aluminum Division Eastern Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? INDUSTRIAL While at work? YES.
(d) Means of injury FELL WHILE WORKING ON ROOF.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 19 1945

G28067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

Registered No. G28067

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Hamburg
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 110 W Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/1881

8. AGE: Years	Months	Days	If less than one day
64	1	-	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business ?

FATHER
12. Name John Redmond
13. Birthplace ?

MOTHER
14. Maiden Name Ellen ?
15. Birthplace ?

16 (a) Informant Nellie Anderson
(b) Address 110 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 APR 20 1945 (Date rec'd by registrar) Harrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/45 19.., at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1944 to Apr. 18 1945 and that I last saw her alive on Apr 17 1945.

	Duration
Immediate cause of death Arthritis Deformans and Toxemia	about 6 mo
Due to Toxemia	
Due to Bedsores	1 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Gaines M.D.
Address 665 W. Baltimore Date signed 4/19/45

VS 3

G28068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G28068

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 N. Gilmor St
(c) Hospital or institution:
16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie Bowman Robinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Harry

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-3-1897

8. AGE: Years 53 | Months 8 | Days 15 | If less than one day: hr. — min. 91

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name William Williams
13. Birthplace Md

MOTHER
14. Maiden Name Fannie ?
15. Birthplace Md

16 (a) Informant Fannie R Gross
(b) Address 1019 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Memy Cem
Location Catonsville Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

19 (a) APR 20 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 45, at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 19 45 to 4/18 19 45.
and that I last saw her alive on 4/18 19 45.

Immediate cause of death Cerebral Hemorrhage
Due to Rt. sided paralysis
Due to Hypertension
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Burleson M. D.
Address 413 Harlem Ave Date signed 4/18/45

X

G28069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28069

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SELMA BANCROFT

3 (b) if veteran, name war —

3 (c) Social Security Account No. 216-24-5789

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876?

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Interior Decorator

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William H Robey
(b) Address 4511 Milwaukee Rd Balto 10 Md

17 (a) Mt Olivet (b) Date thereof 4/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Frederick Rd

18 (a) Funeral director Edward Lanlyn
(b) Address 2209 Wash Blvd

19 (a) APR 20 1945 Registrar
(Date d'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1945; at 1-15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1945 to 4/18 1945, and that I last saw her alive on 4/18 1945

Immediate cause of death	Duration
Cardio-respiratory Failure	5 hrs.
Due to Cerebro-vascular accident	36 hrs
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter X. Shalsley

Address Mercy Hosp. Date signed 4/18/45

X

G28070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G28070 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 Parkdale Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Parkdale Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Walter A Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31-1887

8. AGE: Years	Months	Days	If less than one day
57	2	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James J Grace
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Grace
15. Birthplace Md

16 (a) Informant Walter A Smith
(b) Address 1920 Parkdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd.

18 (a) Funeral director Edward Foulkrod
(b) Address 2359 Wash Blvd

19 (a) (Date rec'd by registrar) APR 20 1945 (b) Huntington for Registrar, M

vs 186

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to — 19—, and that I last saw h— alive on — 19—

Immediate cause of death
a Diabetes Mellitus — Duration

Due to
Due to
Other Conditions Diabetic Gangrene of legs. (Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Donaldson M. D.
Address Medical arts Bldg Date signed 4/19/45

Approved by Howard J. Shaddock, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28071
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E. Balt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Saltzman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Abraham J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph L. Nadich
13. Birthplace Russia

MOTHER
14. Maiden Name Netter
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 4-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) APR 20 1945 (b)
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1945, to April 19 1945, and that I last saw h[illegible] alive on April 19 1945.

Immediate cause of death Pulmonary Edema -
Duration

Due to Cardiac Failure - Hypertension Arteriosclerotic H.D.

Due to Left Hemiplegia Cerebral A.S.

Other Conditions Diabetes - Cystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brom

Address Sinai Hosp Date signed 4/18/45
M D

Huntington Williams, M.D.

939

G28072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G28072

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2305 N. Pulaski St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2305 N. Pulaski St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Abraham John

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Germany Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harris Kahn

13. Birthplace Russia

MOTHER 14. Maiden Name Lena

15. Birthplace Russia

16 (a) Informant Sam Kahn

(b) Address 3713 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rump

Location Park Hgts & Bokeley Lane

18 (a) Funeral director Jack Levin Chas

(b) Address 1439 E. Balto St

19 (a) APR 20 1945 (Date rec'd by registrar) (b) Huntington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19-45 19 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 4/19/45 19; and that I last saw him alive on 4/19/45 19

Immediate cause of death Rheumatic heart disease — Pneumonia —

Due to

Due to

Other Conditions Chr nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: ? | | | | | ? | ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Meeta Bokeley

Address 2904 Rent Rd Date signed 4/19/45 M. D.

VS 150

92a

628073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

Registered 628073

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4600 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Hellelake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Sleedman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Naomi Rose
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel St

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) APR 20 1945 (Date received by Local Registrar) (b) Huntington Hilliard Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20-45 19 , at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 19 45 to 4/20 19 45 and that I last saw him alive on 4/20 19 45

Immediate cause of death

	Duration
acute dilatation	
Due to Thrombosis	1 hr
Due to arteriosclerosis Chronic Bronchitis	5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M J Baylin M.D.
Address 2040 Eutaw Date signed 4/20/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318 Registered No. 628074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 N. Madeira St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 N. Madeira St (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kleina

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marie Kleina
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 26 Jan 1861

8. AGE: Years 84 | Months 2 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Kleina
13. Birthplace Bohemia

MOTHER
14. Maiden Name Marie Sowerth
15. Birthplace Bohemia

16 (a) Informant Mary Kleina
(b) Address 833 N. Madeira

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Frank Boschert Sons
(b) Address 900 N. Eberle St

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

APR 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1944 to 4/18 1945 and that I last saw h... alive on 4/18 1945

Immediate cause of death: Hyp. Sclerotic C.V. disease 4th Degree Decomp
Due to Chronic Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. B. Marsh M. D.
Address 801 N. Linwood Date signed

G28075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G28075 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 E. Fayette St
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman H. [redacted] Vobbe

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-24-1334

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Bertha Vobbe
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Apr. 26, 1874

8. AGE: Years	Months	Days	If less than one day
70	11	26	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation CABINET MAKER
11. Industry or business Glen L. MARTIN

FATHER
12. Name RUDOLPH VOBBE
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISA ?
15. Birthplace GERMANY

16 (a) Informant MRS. BERTHA VOBBE
(b) Address 2619 E EAYETTE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 20, 45 (month) (day) (year)
(c) Cemetery or crematory WESTERN Cem
Location EDMONSON AVE

18 (a) Funeral director L. HEEMANN & Son
(b) Address 32 S. BROADWAY

19 (a) APR 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 19 45, at 7 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.c. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sulewski Medical Examiner. M.D.
Date signed 4/17/45

VS 151

G28076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G28076

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 Wilhelm St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. O'Laughlin

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1870

8. AGE: Years 75 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Andrews
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Leroy F. O'Laughlin
(b) Address 1928 Wilhelm St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21-1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Roth & Stricker
(b) Address Roth & Stricker Sts

19 APR 20 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19th 1945, at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to April 19 1945; and that I last saw her alive on April 19 1945

Immediate cause of death: Cerebral Hemorrhage 2 day

Due to: Myocarditis 1 Month

Other Conditions: Dialysed Ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reginald Dorsey M. D.
Address 7 Mount Street Date signed 4/19/45

628077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

628077 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N. Biddle St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Biddle St (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Virginett Camilla Harris Robertson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1880

8. AGE: Years 64 | Months 11 | Days 5 | If less than one day: hr. min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William Nelson
13. Birthplace Essex Co. Va.

MOTHER
14. Maiden Name Camilla Pitts
15. Birthplace Essex Co. Va.

16 (a) Informant Jacob Harris
(b) Address 228 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mem. Pk.
Location Baltimore Md.

18 (a) Funeral director Chas. H. Stallings
(b) Address 1621 Druid Hill Ave.

19 (a) APR 20 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1945 to April 17 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Chronic Cardiac Failure	8 yrs
Due to arteriosclerosis	4 yrs
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 47 Hamilton Ave. Date signed 4-20-45
For E. J. Lukinski
Howard T. Madeira M.D.

G28078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No. G28078

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 2340 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? [redacted] yes (Yes or No)
If yes, name country Greece & also American

3 (a) FULL NAME Mr Nicholas Doonis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Mrs. N. Doonis

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec 22-1905

8. AGE: Years	Months	Days	If less than one day
39 ~~45~~	3 ~~4~~	24 ~~26~~	hr. min.

9. Birthplace Greece (town, county, and state)

10. Usual Occupation Lunch Room operator

11. Industry or business

FATHER
12. Name Louis Doonis
13. Birthplace Greece

MOTHER
14. Maiden Name Louise ?
15. Birthplace Greece

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-45 (month) (day) (year)
(c) Cemetery or [redacted] Location Lorraine

18 (a) Funeral director Lambros Fun. H. Inc
(b) Address 438-440 E. North Ave

APR 20 1945 (Date rec'd by registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1945, at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1945 to 4/18 1945 and that I last saw h[redacted] alive on 4/18 1945.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Cerebral Hemorrhage.	10 hrs
Due to Hypertension ? Hypertensive [redacted] disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hagerstown, Jr. M. D.
Address Union Memorial Hosp. Date signed 4/19/45

VS 150

(over)

X

628079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 628079

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Philadelphia Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward N. Baker

3 (b) If veteran, name war —
3 (c) Social Security Account No. 171-10-9160

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1887

8. AGE: Years	Months	Days	If less than one day
57	10	10	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Sears Roebuck
FATHER 12. Name George Baker
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name — Bobitz
15. Birthplace Baltimore, Md.
16 (a) Informant Alice Baker
(b) Address 2737 Maryland Ave
17 (a) Burial (b) Date thereof 4/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asbury M.E. Cemetery
Location Reisterstown, Md.
18 (a) Funeral director Howard W. Bright, Jr.
(b) Address 4914 Belair Road
19 (a) APR 20 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18- 1945 at 8:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy or Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-18-45

VS 151

G28080 Schminger

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G28080 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner & Belvedere Aves

(c) Hospital or institution: West Balt. Gen Hosp. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d.

(e) Length of stay in Baltimore (yrs., mos., or days) 79 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2319 Arunah Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA B. SCHIMINGER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife Late George C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1866

8. AGE:	Years	Months	Days	If less than one day
78	79	6	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Maing

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Mrs. Sterling Graham

(b) Address 2319 Arunah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 21 1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Balto. Md

18 (a) Funeral director Harry A. Veitz Co.

(b) Address 4401 Edmondson Ave

19 APR 20 1945 (Date received by Registrar) (b) Washington Williams Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19 1945 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1945 to 4/19 1945, and that I last saw her alive on 4/19 1945

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions Congestive Heart failure + Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. M. Silverfield M. D.

Address West Balt. Gen Hosp Date signed 4/19/45

VS 150

MG28081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B Registered No. G28081 5698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N.
(b) Street address 627 Caehoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) more 6
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Caehoun St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Harcum

3 (b) If veteran, name war unknown

3 (c) Social Security Account No.

4. Sex Male

5. Color or race colored

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Hilda Harcum

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1862

8. AGE: Years 83 | Months 1 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation unknown

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Norman Harcum
(b) Address 627 Caehoun St

17 (a) Burial (b) Date thereof 4-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

19 (a) (b) Huntington Williams MD
(Signature of local registrar) Registrar

APR 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1945, to 4-17 1945 and that I last saw him alive on 4-16 1945.

Immediate cause of death	Duration
Carcinoma of Stomach	unknown
Due to	
Due to	
Other Conditions unknown	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 4-19-45

G28082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

G28082 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.S.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 27
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA MACKEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1889

8. AGE: Years 55 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace St. Marys Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Cooper
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Viola Cannon
(b) Address 1217 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-45 (month) (day) (year)
(c) Cemetery or crematory Carroll Chapel
Location Prince Frederick, Md.

18 (a) Funeral director Mrs Frances A. Hemaley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) APR 20 1945 (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1945 at 7:45A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemopericardium

Due to Dissecting Aneurysm of Aorta

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 19 1945

G28083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G28083 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Maude Kessler

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife William M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1892

8. AGE: Years 52 85 | Months 9 | Days 2/22 | If less than one day hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Bucher
13. Birthplace New Castle Pa

MOTHER
14. Maiden Name Isabella Miller
15. Birthplace Nicholson Pa

16 (a) Informant Wm M Kessler
(b) Address 1513 Park Ave

17 (a) Removal (b) Date thereof 4-22-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Odd Fellows
Location Shoemakers Pa

18 (a) Funeral director William Coyle Inc
(b) Address 1210 Park Ave

19 (a) Filed by registrar Huntington Williams M.D. Registrar

APR 20 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1945 at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Fraker M.D.
Medical Examiner.

Date signed April 20th 1945

G28084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28084

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 453 Lincoln St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Eunice B. Bond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1888

8. AGE: Years 56 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace York, Pa. (Town, county, and state)

10. Usual Occupation Interviewer

11. Industry or business U.S. Employment Service

FATHER
12. Name Allan Bond
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Mackley
15. Birthplace Pa

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)
(c) Cemetery or crematory Prospect Mount
Location York Pa.

18 (a) Funeral director Stuart Moore Co.
(b) Address 108 W Market

19 (a) Date received by registrar APR 20 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1945, at 3:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1945, to April 20 1945, and that I last saw him alive on April 19 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Atelactasis	2 days
Due to Carcinoma of Larynx	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ca of Larynx & pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy B. Turner M. D.
Address Mercy Hospital Date signed 4/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G28085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G28085 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1355 Ausdale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 Ausdale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret D. Ridgeway.

3 (b) If veteran, name war
3 (c) Social Security Account No. 213-12-9911

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W. Race	Married

6 (b) Name of husband or wife E. Chas Ridgeway
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Aug 19- 1914

8. AGE: Years	Months	Days	If less than one day
30	7	24	hr. min.

9. Birthplace Queenstown Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustus Klemmer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Pauline Renes
15. Birthplace Baltimore

16 (a) Informant J. Chas. Ridgeway
(b) Address 1355 Ausdale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dill.
(b) Address 501 E. Fort Ave.
(c)

APR 20 1945
(Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 7 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1943 to April 17 1945, and that I last saw he alive on April 16 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Sa Stevens M. D.
Address 2818 Hanford Rd Date signed 4-19-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

✓ 628086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Woodland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh J. Cummings Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1904

8. AGE: Years 41 | Months 1 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Hartford Co., Md.
(Town, county, and state)

10. Usual Occupation Owner

11. Industry or business Confectionery Store

FATHER 12. Name Hugh J. Cummings Sr.
13. Birthplace Hartford Co. Md.

MOTHER 14. Maiden Name Margaret Sweeton
15. Birthplace Hartford Co. Md.

16 (a) Informant Mrs. Hallie Bolton
(b) Address 902 Cator Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory St. Ignatius
Location Hickory, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Ark 1495

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

APR 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchio-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed April 19 1945

X

G28087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G28087 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Hillsdale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Hillsdale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E. Styne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John W. Styne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18, 1873

8. AGE: Years	Months	Days	If less than one day
71	4	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Harry Helms
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Earls
15. Birthplace Maryland

16 (a) Informant Mrs. Clara C. Jaspert
(b) Address Pittsburgh, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Wells Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) Filed APR 20 1945 (Date filed by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 10.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1944 to April 17 1945, and that I last saw h er alive on April 17 1945.

Immediate cause of death: Pulmonary oedema — Duration: 6 hours
Due to: Myocarditis — 2-3 years?
Due to: Chronic nephritis with hypertension and dropsy — several years
Other Conditions: Diabetes mellitus — several yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Pinkham M. D.
Address 2338 Eutaw Place Date signed

131a

G28088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ G28088 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Alameda
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 31 - 1912

8. AGE: Years	Months	Days	If less than one day
33	3	18	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name John Ed Dorsey
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Lillie Mae Knight
15. Birthplace Balto. Md.

16 (a) Informant Lillie Mae Dorsey
(b) Address 2701 Alameda,

17 (a) Burial (b) Date thereof 4/21/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadowridge.
Location Washington Boulevard.

18 (a) Funeral director John B Connelly
(b) Address 418 Eastern Ave.

19 (a) (b) Registrar
(Date rec'd by registrar)

APR 20 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18- 1945, at 4:27 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1945, to 4-18-1945, and that I last saw her alive on 4-17-1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	Months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. B. Egbert M. D.
Address 402 Hartford Rd Signed 4-18-45

X

628089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

628089 Registered No. 1639

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middleboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. #16, Box 296
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen V. Kroner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward Kroner

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Aug. 5 - 1916

8. AGE: Years	Months	Days	If less than one day
28	8	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert Allers
13. Birthplace Balto.

MOTHER
14. Maiden Name Cathemi
15. Birthplace

16 (a) Informant Edward Kroner
(b) Address Middleborough, Md.

17 (a) Burial (b) Date thereof Apr. 23-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion Luth.
Location Stembers Run

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Balto

19 (a) APR 20 1945 Washington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945 at 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bichromate Potassium Di Chromate Potassium Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-19-45 8:30 P.M.
(b) Where did injury occur? #16, Box 296 - Middleboro
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Ingesting above poison.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-20-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G28090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 S Longwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S Longwood St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William W. Chenoweth

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Blanche L. Chenoweth
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) June 15 1905

8. AGE: Years 39 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Postal Clerk
11. Industry or business U.S. Postoffice

FATHER
12. Name William W. Chenoweth
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Kahl
15. Birthplace Maryland

16 (a) Informant Blanche L. Chenoweth
(b) Address 517 S. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-45 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 210 Frederick Avenue

APR 21 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1944 to 4-18 1945, and that I last saw him alive on 4-12 1945.

Immediate cause of death Uremia
Carcinoma of liver — Duration about 1 yr.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Thomas B. Schreiber M. D.
Address 514 S. Fulton Ave. Date signed 4-19-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G28091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Highfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rob[illegible]augh, Mrs Ida
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr. W. C. Rob[illegible]augh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-1888

8. AGE: Years	Months	Days	If less than one day
56	6	3	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Phillip Haugh.
13. Birthplace Penn.

MOTHER
14. Maiden Name Mary Pope.
15. Birthplace Penna.

16 (a) Informant Mr. W. C. Robb[illegible]augh
(b) Address Highfield Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Waynesboro Pa.

18 (a) Funeral director Walter L. Grove
(b) Address 27 E. Church St, Waynesboro Pa.
(c) Hunting[illegible] Williamsport

APR 21 1945
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1945, at 1.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1945 to 4-20 1945 and that I last saw her alive on 4-20 1945

Immediate cause of death respiratory failure — Duration 1½ hr.

Due to lobar pneumonia, right upper lobe — 1 day

Due to [illegible] pyopneumothorax — [illegible]

Other Conditions Hyperpiesia — 2-3 yrs.

(Include pregnancy within 3 months of death)

Date of operation 4-20-45.

Major findings of operation: Diffuse enlargement of thyroid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Lumsford M. D.
Address Church Home & Hosp. Date signed 4-20-45

G28092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28092

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Edmondi Greene St.
(c) Hospital or institution: Universal Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da
(e) Length of stay in Baltimore (yrs., mos., or days) 16 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or 293 Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 293 Laverne Ave (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME John T Leaf

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bernice K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Sept 12th 1913

8. AGE: Years 31 | Months 7 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation ~~Pipe~~ Fitter Steamfitter

11. Industry or business

FATHER
12. Name Lars Leaf
13. Birthplace Sweden

MOTHER
14. Maiden Name Anna Rose Kreis
15. Birthplace Maryland

16 (a) Informant Bernice Leaf
(b) Address 293 Laverne Ave Lansdowne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by local registrar) (b) Huntington Williamsport Md.

APR 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1945 to 4/20 1945 and that I last saw him alive on 4/20 1945.

Immediate cause of death — Miliary tuberculosis — | Duration

Due to Tuberculous Meningitis

Due to Dextra Position Abdominal Thoracic Agony

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D W Mintzer M. D.
Address Univ. Hospital Date signed 4/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G28093 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247. S Highland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 247. S. Highland ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Burg

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles Burg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 78. Months Days If less than one day hr. min.

9. Birthplace Pittsburg Pa.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Wally J. Rimple
13. Birthplace Pittsburg Pa

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Charles Burg
(b) Address 247. S Highland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Edonwell St.

18 (a) Funeral director Newell J. Dippel
(b) Address 312. S. Highland ave

19 (a) APR 1 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1945 at 6:36 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/7 1945 to 4/8 1945 and that I last saw h. W alive on 4/7 1945

Immediate cause of death: Acute Dilatation of Heart
Due to Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wright J. Beattie
Address 2323 E Baltimore Date signed 4/10/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

628094 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Mc Elderry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Mc Elderry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosa R Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1879

8. AGE: Years 65 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Ricks
13. Birthplace Ga

MOTHER
14. Maiden Name Amanda Giles
15. Birthplace Ga

16 (a) Informant Mrs Thelma DeGraff
(b) Address 2023 Mc Elderry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location City

18 (a) Funeral director Wilson Funeral Home
(b) Address 200 E Preston St

19 (a) (Date filed by registrar) (b) Registrar

APR 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945 at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1944, to April 20 45 and that I last saw h[illegible] alive on April 18 1945

Immediate cause of death Acute Cardiac Failure — Duration 12 hours

Due to Carcinoma of Ascending Colon — Duration 1½ yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Ropp M.D. M. D.
Address 2413 E Monument St Date signed 4/21/45

G28095 X G28095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fourth Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Collar St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr John E. Kennedy.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Anna T Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1885

8. AGE: Years	Months	Days	If less than one day
59	5	0	— hr. — min.

9. Birthplace Baltimore (Belt. County) ; Maryland (Town, county, and state)
10. Usual Occupation Nursery man.
11. Industry or business

FATHER
12. Name Michael Kennedy.
13. Birthplace Ireland

MOTHER
14. Maiden Name Miss Hildt.
15. Birthplace Unknown.

16 (a) Informant Hospital history.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Maryland

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) APR 21 1945 Hunting [illegible] Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945, at 12½ M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1945, to 4-20 1945, and that I last saw h[illegible] alive on 4-20 1945.

Immediate cause of death	Duration
Subcutaneous emphysema & Mediastinal emphysema	
Due to	
Due to Exploratory thoracotomy and repair of Diaphragmatic Hernia	4 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-17-45
Major findings of operations: Diaphragmatic hernia
of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B. Letterman M. D.
Address Church Home & Hosp. Date signed 4-20-45

G28096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

G28096 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 E. Lake Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 E. Lake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha W. Laycock
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James J. Laycock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 5 1860

8. AGE: Years 85 | Months 2 3 | Days 5 | If less than one day hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business "

FATHER
12. Name Asa Henderson
13. Birthplace Ky.

MOTHER
14. Maiden Name Malinda Carr
15. Birthplace Ky.

16 (a) Informant Maud M. Fleming
(b) Address 411 E. Lake ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Richmond Va.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) [illegible] (b) Huntington Williams, M.D. (Registrar) Registrar

APR 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1945 to 4-21 1945 and that I last saw her alive on 4-21 1945

Immediate cause of death Chronic Myocarditis — Duration several years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Gold M. D.
Address 6014 York Road Date signed 4-21-45.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 92766 G28097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1463

Registered No. G28097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas R Sullivan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1902

8. AGE: Years	Months	Days	If less than one day
43	0	20 27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Sullivan
13. Birthplace Md.

MOTHER
14. Maiden Name Lillie Wissell
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof April 24-45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Baltimore Cemetery
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave.

19 (a) (b)
(Date filed by registrar) APR 24 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945; at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26, 1945 to April 20 1945 and that I last saw h im alive on April 20 1945

Immediate cause of death	Duration
Carcinoma of the Stomach	6 mos.
Due to	
Due to	
Other Conditions Pulmonary tuberculosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Edmunds M. D.
Address Balt. Maryland Date signed 4-30-45

MG 28098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 159

Registered No. 28098

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 45 N. Kresson St (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Meninger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business —

FATHER
12. Name Louis Meninger
13. Birthplace Md.

MOTHER
14. Maiden Name Kelma Kerr
15. Birthplace Balto. Md.

16 (a) Informant Mr. Meninger
(b) Address 45 N. Kresson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 21 45 (month) (day) (year)
(c) Cemetery or crematory Meninger Cem.
Location Balto. Co. Md

18 (a) Funeral director Leonard Funeral Home
(b) Address 7401 Harlem Rd.

APR 21 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945, at 12 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1945, to 4-20 1945, and that I last saw him alive on 4-19 1945.

Immediate cause of death: Cerebral anopemia — Duration: 2 days
Due to:
Due to:
Other Conditions: Prematurity — 7 mos.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Fairbanks M. D.
Address Maryland General Hospital Date signed 4-21-45

G28099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12a

Registered No. G28099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3802 - Chatam Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 & 10
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Chatam Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret L. Mc Crea

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Walter Mc. Crea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 1870

8. AGE: Years 75 | Months 3 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. B. Bozerman
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Emily Jane Stockdale
15. Birthplace Carroll Co.

16 (a) Informant Melissa E. Pfeffer.
(b) Address 3802 Chatam Rd. Balto city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24-45 (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Reisterstown Balto. Co.

18 (a) Funeral director J. F. Elsner Sons
(b) Address Reisterstown Md

19 APR 21 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 45, at 12 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 45, to April 21 19 45, and that I last saw h[illegible] alive on April 21 19 45.

Immediate cause of death ..... Duration
Uremia
Nephritis
Due to Malignant obstruction of Ureter
Pyelonephritis and Ureteritis
Due to Pyelonephritis. 2 mos

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury W. E. Needle

23. Signature
Address 2314 - 00. North Ave Date signed 4/21/45 M. D.

G28100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G28100 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St. Joseph's Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2331 Oliver St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA MARIE BRAMBLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel W. Bramble

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1894

8. AGE: Years	Months	Days	If less than one day
50	7	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Nurse.

11. Industry or business

FATHER 12. Name Henry Schuppner

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Rosena ~~Bayne~~ Wilson

15. Birthplace Md.

16 (a) Informant Mr. Samuel W. Bramble

(b) Address 2331 E. Oliver St.

17 (a) Burial (b) Date thereof 4/24/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 APR 21 1945 Worthington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1945 to 4/20 1945 and that I last saw her alive on 4/20 1945.

Immediate cause of death Congestive Heart Failure — Duration

Due to Cardiac decompensation

Due to Cancer of cervix

Other Conditions Possible uterine fibroid

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Nathan E. Cheek M. D.

Address St. Joseph's Hosp. Date signed 4/20/45

VS 150

628101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. 628101

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33d + Calvert

(c) Hospital or institution: Union Memorial 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Roland Park (If outside city or town limits, write RURAL and give town)

(d) Street No. 4711 E. Lane (If rural give location) EAST LA.

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Hans Nielsen Boetcher

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-05-6430

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ruth Jewel Boetcher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-98

8. AGE: Years	Months	Days	If less than one day
47	2	4	hr. min.

9. Birthplace Hamburg Germany (Town, county, and state)

10. Usual Occupation Mech. Engineer

11. Industry or business Cons. Gas & Elec. Co.

FATHER 12. Name Morris Boetcher

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Marianna Müeller

MOTHER 15. Birthplace Germany

16 (a) Informant Self

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 21, 1945 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto., Md.

18 (a) Funeral director Wm. J. Tydeman & Sons

(b) Address Balto., Md.

APR 21 1945 Date rec'd by registrar — Arlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945 at 8:31 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1945 to 4-19 1945 and that I last saw h[illegible] alive on 4-19 1945

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Cholelithiasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-11-41

Major findings of operation: Gall stones

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.

Address U.M.H. Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

628102

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

628102

92 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland St. Laynes Lane
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 S Caley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence V. Backoff

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Michael F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1884.

8. AGE: Years 60 Months 7 Days 12. If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation house work.

11. Industry or business at home

FATHER
12. Name Geo W. Woodall
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Sarah E. Jackson
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Lloyd J. Backoff
(b) Address 1410 S. Caley St.

17 (a) Burial, cremation, or removal Funeral (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem
Location Loney, Md

18 (a) Funeral director John J. Cowan & Son
(b) Address 9003 Pulaski St

19 (a) (Date received by local registrar) APR 21 1945 (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 3 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945, to April 19 1945, and that I last saw h.e.r. alive on April 19 1945.

Immediate cause of death Coronary Thrombosis mins infarction — Duration

Due to Rheumatic Cardiac vascular disease mitral stenosis

Due to Congestive Heart Failure Pulmonary Edema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D. Beckmann M. D.
Address West Baltimore General Hospital Date signed 4/19/45

VS 150

628103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

628103 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1944 N. Collins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1944 N. Collins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Telton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine M. Telton
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb 4-1881

8. AGE: Years 64 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Auto Supplies Co

FATHER
12. Name John H. Telton
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina C. Lentz
15. Birthplace Maryland

16 (a) Informant Catherine M. Telton
(b) Address 1944 N. Collins St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/21/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director J. D. Klippert Inc
(b) Address 651 W. Baltimore St

19 (a) APR 21 1945 (Date rec'd by registrar)

Hunting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th 1945 at 9:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to April 18 1945; that I last saw h alive on April 11 1945.

Immediate cause of death: Cardiac Failure — Duration: 2 weeks
Due to: Coronary Thrombosis
Due to: Generalized arterio sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Yaffe M. D.
Address 3101 W Baltimore St Date signed APR 20 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28104 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 W. North Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Bertha Emory Mehring

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced
Female White (SINGLE)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-70

8. AGE: Years 74 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Lutheran Deaconess

11. Industry or business

FATHER 12. Name Samuel Mehring
13. Birthplace Pa

MOTHER 14. Maiden Name Anna E Crumbine
15. Birthplace Pa

16 (a) Informant Lutheran Deaconess Home
(b) Address 2500 W. North Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory LORRAINE-PARK
Location WOODLAWN - MD.

18 (a) Funeral director F. D. WIPPERT, SON
(b) Address 1300 EUTAW-PLACE

19 (a) (Date rec'd by registrar) APR 21 1945 (b) Registrar Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20-45 19 , at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-45 19 , to 4-20-45 19 , and that I last saw her alive on 4-20-45 19

Immediate cause of death Cardiac Failure — Duration

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Franklin Bandy M. D.
Address Md. Gen. Hosp. Date signed 4-20-45

937

G28105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G28105
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6100 Leighton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy E. Seeberger
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed or divorced. Married
6 (b) Name of husband or wife John F. Seeberger
(c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) 5/6/09
8. AGE: Years 36 Months 11 Days 14 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Secretarial

FATHER
12. Name Anthony Madary
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Ida C. Snyder
15. Birthplace W. Va.

16 (a) Informant Mrs. John F. Seeberger
(b) Address 6100 Leighton Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore
18 (a) Funeral director Leonard J. Kuck
(b) Address 5805 Harford Rd.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
APR 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at 7:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1945, to 4/20 1945, and that I last saw h[illegible] alive on 4/20 1945.

Immediate cause of death Encephalitis
Due to Carcinoma of Descending Colon
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis J. Foutz M.D.
Address St. Joseph's Hosp. Date signed 4/22/45

VS 150

G28106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28106

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 McCulloh (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellsworth Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1929

8. AGE: Years	Months	Days	If less than one day
15 16	8	16	hr. min.

9. Birthplace Baltimore, Md.. (Town, county, and state)

10. Usual Occupation School boy.

11. Industry or business

FATHER
12. Name Howard Turner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth -
15. Birthplace Va

16 (a) Informant Howard Turner
(b) Address 629 N. Calhoun

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 332 N. Schroeder St.

19 (a) APR 21 1945 (Date received by registrar) (b) Huntington Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945; at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13-1945, to 4-19-1945, and that I last saw him alive on 4-19-1945.

Immediate cause of death Meningitis, meningococcic — Duration 4 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 4/19/45

X

G28107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G28107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Bentz St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Frederick Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W. Chase
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Swan
15. Birthplace Md.

16 (a) Informant Mr. William Hill
(b) Address 20 S. Bentz St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem
Location Frederick, Md.

18 (a) Funeral director McKendree R. Etchison
(b) Address 106 E. Church St.

19 (a) Filed 4-23-1945 (Date registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1945 at 12:38 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/45 19__ to 4/21/45 19__ and that I last saw h alive on 4/21 1945

Immediate cause of death Pulmonary embolism or Coronary thrombosis

Due to Arteriosclerosis moderate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 Months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rectenwald M. D.

Address Wm. Harp Date signed 4/21/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28103 ✓ G28103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Lillian Leviton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Zelik Finestone
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Mrs Rose Taylor
(b) Address 428 N Aisquith St

17 (a) Burial (b) Date thereof April, 22. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) APR 22 1945 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION 6.30

20. DATE OF DEATH April 20 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to April 20 45
and that I last saw h[illegible] alive on April 20 1945

Immediate cause of death Coronary Occlusion — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 3322 Callow Ave Date signed April 23, 1945

VS 150

X

G28109 ✓ G28109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Greenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Riga
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Daniel Dembo
13. Birthplace Riga

MOTHER
14. Maiden Name Ida ?
15. Birthplace Riga

16 (a) Informant Jesse Greenfeld
(b) Address 3501 Woodbrook Ave

17 (a) Burial (b) Date thereof April 22. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) APR 22 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION 12.45

20. DATE OF DEATH April 21 1945, at A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/10 1940, to 4/21 1945, and that I last saw h[illegible] alive on 4/21 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to Malnutrition	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 1[illegible] W. Lee Date signed

X 4/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

628110

Registered No. 4612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Pearl L. Silver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Julius Silver
13. Birthplace Poland

MOTHER
14. Maiden Name Rose ?
15. Birthplace Poland

16 (a) Informant Morris Silver
(b) Address 406 Aisquith St

17 (a) Burial (b) Date thereof April 22, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Apr 20 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION 12.15

20. DATE OF DEATH April 20, 1945 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1944 to 1945, and that I last saw h[illegible] alive on almost one month ago

Immediate cause of death Chronic Lymphatic Leukemia
Consequence Stomach Ca
Due to Asthma Bilateral Heart disease
Cardiac dilatation

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred Ullman M. D.
Address 1711 Eutaw Place Date signed 4-20-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G28111 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colvert
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) City or County of Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Linden Heights
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** James J. Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Dec'd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-76

8. AGE: Years 68 | Months 5 6 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Hosp. chart.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Erin
Location Havre de Grace

18 (a) Funeral director Permenter & Son
(b) Address Havre de Grace

19 (a) APR 23 1945 (Date received by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1945, at 5.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1945, to 4-21 1945, and that I last saw h. live alive on 4-21 1945.

Immediate cause of death Cardio-resp failure — Duration .....

Due to Arterio sclerotic cardio-vascular renal disease — Duration .....

Due to ..... — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Paul E. Crump M. D.
Address Union Memorial Hospital Date signed 4-24-45

Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G28112 93185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161B

Registered No. G28112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 4th. St Brooklyn Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Murray ~~Lawrence Murray~~ Shade Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8th 1945

8. AGE: Years | Months | Days 12 days | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Laundress

FATHER
12. Name Lawrence Harry Shade
13. Birthplace Maryland

MOTHER
14. Maiden Name Teresa Tansley
15. Birthplace Penn.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof April 23 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Bern
Location Balto City

18 (a) Funeral director E. Howard Evans & Son
(b) Address 1400 S. Charles St

19 (a) [illegible] 1945 (b) [illegible] for Williams

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20th, 1945 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945 to Apr. 20 1945 and that I last saw h M alive on April 20 1945.

Immediate cause of death Sepsis (staph. aureus). — Duration 3 Days

Due to Omphelitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Terminal Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter W. Torem

Address Baltimore City Hosp. Date signed M. 4 D. 25 1945

X

G28113 ✓ G28113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Warner Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Warner Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary W Rhodes

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	widowed ✓

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/93

8. AGE: Years	Months	Days	If less than one day
51 52	3	29	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard Graney
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace N. C.

16 (a) Informant Grace Hoffman
(b) Address 1000 Warner Street

17 (a) Removal (b) Date thereof 4/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Gasonia N. C.

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1080 W Montgomery Street Huntington Williams, Mgr.

APR 22 1945
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 2 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10, 1945, to April 21 1945, and that I last saw h[illegible] alive on April 20 1945.

Immediate cause of death	Duration
Cardio Renal Disease	10 weeks
Due to Hypertension	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Bradman Higgins
Address 943 Madison Ave Date signed 4/24/45 (M./D.)

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JO #92648 G28114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

156a ✓ G28114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Molly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1890

8. AGE: Years	Months	Days	If less than one day
54	-3-	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unable to obtain information
11. Industry or business

FATHER
12. Name Zebedee
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Weems (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. a. Co. Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1021 N Montgomery St

19 (a) Huntington Williams (Signature of registrar) Registrar
(Date received by registrar) APR 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1945, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19, 1945, to Apr. 17, 1945, and that I last saw him alive on Apr. 17, 1945

Immediate cause of death: Pulmonary infarction — Duration 3 hrs?
Due to: Strep. septicemia — 1 month
Due to: — ?
Other Conditions: Bilateral femoral thrombosis. Strep. arthritis of knee — 1 month
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 4-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28115 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 Eutaw pl
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Eutaw place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Max Adler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years 97 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Joseph Adler

13. Birthplace Russia

MOTHER 14. Maiden Name Ida

15. Birthplace Russia

16 (a) Informant Mrs Sophia Adler

(b) Address 2031 Eutaw Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22/45 (month) (day) (year)

(c) Cemetery or crematory Mishkan Israel Cem

Location Southern ave

18 (a) Funeral director Sol Levinson & Bro

(b) Address 1124 & 26 W. North ave

(b) Huntington Williams, M.D.

APR 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945 at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 21 1945 and that I last saw [illegible] alive on April 20-45

Immediate cause of death: Uremia Cardiac dilatation — Duration 2 days

Due to Chron. Nephritis 6 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M J Bayer M.D.

Address 2040 Eutaw Pl Date signed 4/21/45

VS 150

G28116

G28116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona ave
(c) Hospital or institution:
Edmondson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Pasovsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Sidney Pasovsky
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Mr Jack Parks
(b) Address North Ave & Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22, (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Apr 2 1945 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 4.40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-00-18 1943 to April 22 1945 and that I last saw h alive on April 2 1945

Immediate cause of death Chronic Nephritis uremia

	Duration
Due to	
Due to	
Other Conditions Cerebral Edema uremia & Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wa Rothenberg M. D.
Address 1120 W North Ave Date signed April 22, 45

G28117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28117
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N Luzerne ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N Luzerne ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bauer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Bauer
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 20 1890

8. AGE: Years	Months	Days	If less than one day
54	8	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Police
11. Industry or business

FATHER
12. Name Matthew Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Katherine Bauer
(b) Address 508 N Luzerne ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) 23 1945 (Date received by registrar) (b) Lexington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945 at 8 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to April 18 1945, and that I last saw him alive on April 18 1945.

Immediate cause of death

	Duration
Pneumonia, Septicemia	2 wks
" acute Endocarditis	2 wks
Due to Left Brachial artery occlusion	"
Due to Cerebral embolism	"
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Kehnes M. D.
Address 2623 E. Monument St Date signed 4/20/45

VS 150

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28118 G28118

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Newkirk St., 7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Ellen A. Grogan 6

If U. S. Veteran specify WAR

(a) Residence: No. 318 S. Newkirk St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 22 1945

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of John F. Grogan

6. DATE OF BIRTH (month, day, year) Dec. 2, 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	4	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Scranton
(State or country) Pa.

FATHER

13. NAME Patrick Gilleran

14. BIRTHPLACE (city or town) Ireland
(State or country)

MOTHER

15. MAIDEN NAME Bridgett Berg

16. BIRTHPLACE (city or town) Ireland
(State or country)

17. INFORMANT Margaret L. Lundberg
(Address) 318 S. Newkirk St

18. BURIAL, CREMATION, OR REMOVAL
Place Scranton Pa. Date 4/27/45

19. UNDERTAKER Wm. H. Eyerman Funeral Home
(Address) 2004 Eastern Ave.

20. FILED ..... 19..... Registrar.

Huntington Williams

VS 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 22, 1945

22. I HEREBY CERTIFY, That I attended deceased from April 14, 1945 to April 22, 1945

I last saw her alive on April 21, 1945 Death is said to have occurred on the date stated above, at 5:00 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis C.V. Disease.	
Acute Gastro enteritis	4-14-45
Chronic Myocarditis	4-14-45
Pneumococcal Peritonitis	4-14-45

Other contributory causes of importance:

None

Was an operation performed? Yes Date of

For what disease or injury?

Name of operation None.

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? None Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) E. Schumacher M. D.

(Address) 942 S. Ford Ave

X

[redacted] G28119 BALTIMORE CITY HEALTH DEPARTMENT [redacted] Registered No. G28119

CERTIFICATE OF DEATH 1937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 Fennick Av
(c) Hospital or institution: [redacted]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Fennick Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. West

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, ~~or divorced~~ W

6 (b) Name of husband or wife Geo A West

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1/5/1867

8. AGE: Years 77 | Months 3 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Balto (town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business —

FATHER 12. Name George Foster
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Rististella
15. Birthplace Germany

16 (a) Informant Mrs Lee Bush
(b) Address Randall Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd & [illegible]

18 (a) Funeral director John J Tschiesch
(b) Address 1337 S Ellwood Av

19 (a) 4/22/1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945, at 1.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1945 to April 20 1945, and that I last saw him alive on April 19 1945

Immediate cause of death Myocardial Insufficiency

Due to —

Due to —

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John J Tschiesch, M.D.
Address 1337 S. Ellwood Av Date signed 4/26/45

[redacted] G28120 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

[redacted] Registered No. G28120

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts - Charles & 31st (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Miss Mary Rositer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/166

8. AGE: Years 78 | Months 9 mos | Days 27 ds | If less than one day ... hr. ... min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Lawrence Rositer
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Doyle
15. Birthplace Ireland

16 (a) Informant Mrs C Ida Rositer
(b) Address Homewood Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director Joseph Taylor & Sons
(b) Address 3 N Liberty St

19 (a) 22 1945 (Date rec'd by registrar) (b) Lurington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945 to April 20 1945 and that I last saw her alive on April 20 1945.

Immediate cause of death: Cardiac failure — Duration

Due to Subacute cardiac decompensation

Due to Art. Arteriosclerotic C. V. renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry L. Colfer, M. D.

Address Date signed 4/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-15893 G28121 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1945 Registered No. G28121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs- 11mos-10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30- 1866

8. AGE: Years	Months	Days	If less than one day
78	9 11	15 13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Lane (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Gillcrest (D)
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location Gleanmore Hill Rd

18 (a) Funeral director John J. Halpin & Sons
(b) Address 1918 Eastern Ave.

19 (a) APR 23 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13- 1945, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5- 1936 to 4- 13 1945, and that I last saw Him alive on 4-13 1945

Immediate cause of death Pneumonia — Duration 4 Days

Due to — Duration

Due to — Duration

Other Conditions Heart failure arteriosclerosis Ht. Disease — Duration 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature J. M. Phillippi
Address Balt City Hosp Date signed 4-21-45

107

G28122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G28122 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31 St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo.21 days
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Hazel Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 E. Meyers,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Smith, Allen J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1902

8. AGE: Years	Months	Days	If less than one day
42	5	26	hr. min.

9. Birthplace Turner Township, Mich.
(Town, county, and state)

10. Usual Occupation oiler

11. Industry or business Seafaring

FATHER
12. Name Alexander Smith
13. Birthplace Bingham, Mich.

MOTHER
14. Maiden Name Caroline Schantz
15. Birthplace Ontario, Canada

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Wyman Park Drive and 31st.St. Baltimore, Md.

17 (a) Burial (b) Date thereof 4-25-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Ubly, Michigan

18 (a) Funeral director A. Lee Odell
(b) Address 1644 York Rd.

19 (a) APR 22 1945 (b) Huntington Williams Mfr.
(Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 8:25AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945, to April 21 1945, and that I last saw him alive on April 21 1945.

Immediate cause of death Reticulum cell lymphosarcoma

Duration 9 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.F. van Ackeren M. D.
Address Baltimore, Md. Date signed 4/21/45

G28123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28123
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hosp -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Overlea (If outside city or town limits, write RURAL and give town)
(d) Street No. 7005 Dunbar Ave (If rural give location)
(e) Citizen of foreign country Overlea Md (Yes or No)
If yes, name country

3 (a) FULL NAME Lorace Williams

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 717-07-6821

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Amelia E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 1873

8. AGE: Years 71 | Months 6 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. County, Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Gilson Williams
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Elizabeth Fitzgerald
15. Birthplace Balto. Co. Md.

16 (a) Informant Herbert C. Williams
(b) Address Marie M. Dannemann

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorsuch Mill Rd.

18 (a) Funeral director Martin W. C. Oppelsons
(b) Address 7110 Belair Rd.

19 (a) 4/23 1945 (b) [illegible] for Williams, M.D. Registrar
(Signature of local city registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at 2:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 19 45 to 4/20 19 45, and that I last saw h[illegible] alive on 4/20 19 45

Immediate cause of death: Cerebral Vascular Accident

Due to: Arteriosclerosis

Due to:

Other Conditions: Benign Prostatic Hypertrophy, Pneumonia
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Stein (M.D.)
Address St Agnes Hosp Date signed 4/23/45

VS 150

G28124

JL - 92976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22

G28124 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1122 Druid Hill Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Lillian Belle Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1906

8. AGE: Years	Months	Days	If less than one day
38	5	6	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER
12. Name Willie Montgomery
13. Birthplace S. C.

MOTHER
14. Maiden Name Maria Voghn
15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location A. A. Cemetery

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna Ave

19 (a) APR 23 1945 (b) (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 12.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6, 1945 to April 21 1945, and that I last saw her alive on April 21, 1945

Immediate cause of death	Duration
Cardiac failure	2
Due to	
Due to	
Other Conditions Miliary Tuberculosis	2 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Woodward M. D.

Address Date signed

VS 150

8 X

Geo. Shannon
Med. Arts G28125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

G28125
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3801 Sequoia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Sequois Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie G. Heying

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Louis T. Heying Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas Mayer
13. Birthplace ?

MOTHER
14. Maiden Name Susannah ?
15. Birthplace ?

16 (a) Informant Mr. Louis T. Heying Sr.
(b) Address 3801 Sequioa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) [illegible] (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945 at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1944 to Apr. 19 1945, and that I last saw her alive on Apr 19 1945.

Immediate cause of death Acute Dilatation Heart. — Duration

Due to

Due to

Other Conditions Chr. myocarditis.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 720 med. Arts Bldg Date signed 4/20/45

APR 23 1945

Huntington Williams, M.D.

VS 150

G28126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G28126 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 East Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George F. Fink
3 (b) If veteran, name war Spanish War.
3 (c) Social Security Account No. no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 18-1870
8. AGE: Years 74 | Months 7 | Days 13 | If less than one day hr. min. 75
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Fink
13. Birthplace Germany

MOTHER
14. Maiden Name Mat Brian
15. Birthplace

16 (a) Informant Catherine Fink
(b) Address 2924 E. Madison St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd
18 (a) Funeral director Geo M. Fink & Son
(b) Address 811 N Wolfe St
19 (a) (b) Huntington Williams, M.D.

APR 23 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1945, at 11:57 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1945 to 4/21 1945 and that I last saw h[illegible] alive on 4/21 1945

Immediate cause of death: Terminal Pneumonia — Duration: 2 days
Due to Carcinoma Tail of Pancreas with Metastasis to Liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 4/24/45

G28127 ✓ G28127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3/4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 N. APPLETON AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JESSE WIDERMAN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: LOUISE WIDERMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 1891

8. AGE: Years	Months	Days	If less than one day
54	3	17	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation CHAUFFEUR
11. Industry or business

FATHER
12. Name Clarence Widerman
13. Birthplace Md

MOTHER
14. Maiden Name Mamie Ritter
15. Birthplace Md

16 (a) Informant WIFE
(b) Address 1018 N. APPLETON AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Randallstown

18 (a) Funeral director William Cook.
(b) Address 1217 St Paul St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

APR 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1945, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19/ 1945, to 4/21 1945, and that I last saw him alive on 4/21 1945.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration:

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to

Other Conditions: LEFT INGUINAL HERNIA (Include pregnancy within 3 months of death)

Date of operation 4/20/45

Major findings of operation: LEFT INGUINAL HERNIA, HEMATOMA IN INGUINAL AREA

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: HERNIA
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 4/19/45 at M
(c) Where did injury occur? Balto. (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? INDUSTRIAL (Specify type of place) While at work?
(e) Means of injury RISING FROM SQUATTING POSITION

23. Signature Paul F. Herold M. D.
Address Md. General Hosp. Date signed 4/21/45

X

Read on arrival 9:00 a. m. G28128

BALTIMORE CITY HEALTH DEPARTMENT ✓ G28120

CERTIFICATE OF DEATH 1190

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 N. Belnord St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Elizabeth Jenkins. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 14 1944

8. AGE: Years | Months: 9 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Daniel Jenkins
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary Boykin
15. Birthplace: Balto. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, removal
(b) Date thereof (month) (day) (year) 4/24/45
(c) Cemetery or crematory: Woodland Memorial
Location: Baltimore Md

18 (a) Funeral director: Wilhoms Funeral Home
(b) Address: 1217 E. Pratt St.

19 (a) (Date rec'd by registrar) APR 23 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Anesthesia

Duration

Due to

Due to

Other Conditions: Diarrhea

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No cause of death

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Francis W. Halfpinch M. D.
Address: Johns Hopkins Hospital Date signed 4-20-45
Howard J. Mendelsohn, M. D. ✗

G28129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G28129

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ******
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME R. Walter Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7th. 1884

8. AGE: Years	Months	Days	If less than one day
61	3	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name R. Walter Watkins Sr.
13. Birthplace Virginia

MOTHER
14. Maiden Name Susie B. McKenzie
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Milton Eney
(b) Address 725 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Geo. L. Bayer Jr
(b) Address 1512 Hollins St.

19 (a) APR 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 20 1945, at 2:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 1945, to Apr 20 1945, and that I last saw him alive on Apr 19 1945.

Immediate cause of death: Carcinoma Pharynx — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W B Eaman and Lond M. D.
Address 2200 Garrison Blvd Date signed 4/23/45

628130 ✓ 628130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /21

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7 Fayette & Calhoun

(c) Hospital or institution: 7 Franklin Sq. Hospital ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5613 Benton Heights Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME George J. Eiring

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife LENA M. EIRING

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 4 1889

8. AGE: Years	Months	Days	If less than one day
55	10	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation SUPT. OF MT. VERNON

11. Industry or business DIS. CO.

FATHER 12. Name Henry EIRING

13. Birthplace Maryland

MOTHER 14. Maiden Name Ewa Herold

15. Birthplace Maryland

16 (a) Informant HOSP. RECDS.

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 25/45 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Selby & Zeiler Sons

(b) Address 403 S. WOLFE ST.

19 APR 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1945, at 5:20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1945 to 4-22 1945, and that I last saw him alive on 4-22 1945

Immediate cause of death: acute cardiac decompensation — Duration: 2 days

Due to: Post operative status asthmaticus — 3 days

Due to:

Other Conditions: Chronic bronchial asthma

(Include pregnancy within 3 months of death)

Date of operation 4-17-45

Major findings of operation: acute appendicitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature N. K. Kezarian M. D.

Address 7 Franklin Square Hospital Date signed 4-22-45

VS 150

628131 ✓ 628131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1572

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: St. Joseph's Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/48

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 14 Gantz Court

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Garmong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed,~~ or divorced.

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. 25 min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Raymond M. Garmong

13. Birthplace Louisville, Ky.

MOTHER 14. Maiden Name Cora L.

15. Birthplace Louisville Kentucky

16 (a) Informant Raymond M. Garmong

(b) Address 14 S. Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director A. J. Burch

(b) Address 5305 Harford Rd.

19 (a) [illegible] (b) APR 23 1945 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 11 08 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945 to April 21 1945, and that I last saw him alive on April 21 1945.

Immediate cause of death	Duration
Hydrocephalus	
Spina Bifida	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Eugene J. Riley M. D.

Address St. Joseph's Hospital Date signed 4-22-45

VS 150

G28132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28132 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank P. Venditti

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	219-20-5903

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of ~~husband~~ wife Rosa Venditti
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 21 1871

8. AGE: Years	Months	Days	If less than one day
73	4	29	hr. min.

9. Birthplace Casalvecchio di Puglia Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Michele Venditti
13. Birthplace Italy

MOTHER
14. Maiden Name Margherita?
15. Birthplace Italy

16 (a) Informant Rosa Venditti (Wife)
(b) Address 4106 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd. Dundalk Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by Registrar) APR 23 1945 (b) Huntington Hilleary Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20- 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942 to April 20 1945 and that I last saw him alive on April 20 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 1 wk

Due to Cerebral and Gen'l arteriosclerosis — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B. Askenasy M. D.
Address 463 Park Heights Ave Date signed 4-23-45

X

628133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

628133
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Dates correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 2420 Ellamont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Ellamont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age 18 Yrs

7. Birth date of deceased (mo., day, yr.) 4-19-1866

8. AGE: Years 79 | Months | Days 2 | If less than one day ..... hr. 1866 min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Franura. Michel

13. Birthplace — —

MOTHER 14. Maiden Name Adolphenia Koch

15. Birthplace — —

16 (a) Informant Mrs Chas. Schwarz

(b) Address 2420 Ellamont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 3500 Old Fred. Rd.

18 (a) Funeral director Harry N. Wetzel

(b) Address 4101 Edmondson Ave

19 (a) ..... (b) ..... Registrar

Date received by registrar APR 28 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21/45 19 , at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. R. Lubinski M.D.
Medical Examiner.

Date signed 4/25/45

(over)

G28134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56D

Registered No. G28134

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Frank A. Ballman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1895

8. AGE: Years	Months	Days	If less than one day
49	4	9	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation District Manager
11. Industry or business Moore Bus. Forms Inc.

FATHER
12. Name Frank A. Ballman
13. Birthplace Balto.

MOTHER
14. Maiden Name Agnes Bowles
15. Birthplace Balto.

16 (a) Informant Paul N. Ballman
(b) Address 3206 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Tracy A. Wright
(b) Address 4101 Edmondson ave

19 (a) APR 23 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21/45 19 at 3.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1943 to April 21 1945, and that I last saw him alive on April 21 1945.

Immediate cause of death Status epilepticus

Due to: ? Idiopathic epilepsy
? Brain tumor

Due to

Other Conditions: ? Cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Epileptic spells for 5 yrs
Status for 6 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard N. Tillman M. D.
Address 3025 St. Paul St Date signed April 23 1945

Funeral from Pikesville, Md

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28135 — BALTIMORE CITY HEALTH DEPARTMENT — G28135

TN. 89385 — CERTIFICATE OF DEATH 107 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8-Mo. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1515 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME Laura Gaither

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1863

8. AGE: Years	Months	Days	If less than one day
?81	? 11	?	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Nelson Groom
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Sarah Ellen ?
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Jen
Location: Balto. Co.

18 (a) Funeral director: Samuel W. Sullivan Jr.
(b) Address: 117 N. Hamilton Ave

19 (a) APR 23 1945 (Date received by local registrar) Huntington Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20th, 1945, at 12.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13-44 to 4-20-45 and that I last saw h[er] alive on Apr. 20th 1945.

Immediate cause of death: Pneumonia (Pneumonia ?) — Duration: ?

Due to:

Due to:

Other Conditions: Hyp. Arteriosclerosis Bronchopneumonia (Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: E. Woodward M. D.
Address: Baltimore City Hospitals Date signed 4-22-45

90B

628136 ✓ 628136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1897

8. AGE: Years	Months	Days	If less than one day
47 yrs	9	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Jacob Jones

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Barkley

15. Birthplace Maryland

16 (a) Informant Henrietta Deshields

(b) Address 560 Orchard Street

17 (a) Burial (b) Date thereof 2-25-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 23 1945

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1945, at 2.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Stab wound of chest involving the superior Vena Cava.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-19-45 at 2.30 P.M.

(b) Where did injury occur? 705 Vine Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Stab Instrument

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 4-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

Registered No. G28137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 662 Bradley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 662 Bradley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monroe Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1901

8. AGE: Years 44 | Months 1 | Days 9 | If less than one day: hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. Lillian Hake
(b) Address 632 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b) Huntington Williams, M.D. Registrar

Date received by registrar APR 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 19, 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 19 1945 to 4/19/45 19; and that I last saw h. alive on 4/19/45

Immediate cause of death: Acute Dilatation Lungs — Duration: 2 days
Due to: Myocarditis — Duration:
Due to: Ancurism in Aorta — Duration:
Other Conditions: Syphilis?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address Har. Elec. Md. Date signed 4/24/45

G28138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B ✓ G28138 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 Jefferson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Albert Elmer Brown Sr.

3 (b) If veteran, name war: --
3 (c) Social Security Account No. 217-09-1996

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28,1885

8. AGE: Years 59 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace: Balto.Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Chas.L.Brown
13. Birthplace: Balto.Md.

MOTHER
14. Maiden Name: Elizabeth Watts
15. Birthplace: Balto.Md.

16 (a) Informant: Mrs.Katherine Brown
(b) Address: 2806 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr.23/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem.Park
Location: Balto.Md.
18 (a) Funeral director: Philip Sherwin Sons
(b) Address: 2024 Orleans St.
19 APR 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr.19/45 19..., at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 19 44 to April 19 1945, and that I last saw him alive on 4/19 1945.

Immediate cause of death	Duration
Congestive cardiac insufficiency	3 wks.
Due to Pulmonary Phthisis.	3 years
Due to Phthisis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Tolliver M. D.
Address 947 N. Kenwood Ave Date signed 4/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G28139

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3414 Cedardale Road.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3414 Cedardale Road. (Rural route location)

(e) Citizen of foreign country? Germany (Yes or No)

If yes, name country

3 (a) **FULL NAME** Edward Hainz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	W.

6 (b) Name of husband or wife Katherine A. Tolpfer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1867

8. AGE: Years	Months	Days	If less than one day
78	3	9	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Butcher.

11. Industry or business Self Employed.

FATHER 12. Name John L. Heinz

13. Birthplace Germany

MOTHER 14. Maiden Name Amanda Pahnke.

15. Birthplace Md.

16 (a) Informant Family

(b) Address 3414 Cedardale Road.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-23-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park.

Location Frederick Rd.

18 (a) Funeral director Edward L. Tickner

(b) Address 130 E. Fort Ave.

19 (a) APR 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945, to April 19 1945, and that I last saw h. alive on April 19 1945.

Immediate cause of death Carcinoma of Stomach — Duration about 6 mo.

Due to

Due to

Other Conditions Secondary Anemia — 3 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter S. Hilpert M. D.

Address 220 Harrison Blvd Date signed April 20/45

628140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52 B

628140
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S Broadway
(c) Hospital or institution: Church Home Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Park Apts.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Wennagel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1887

8. AGE: Years	Months	Days	If less than one day
58	3	7	— hr. — min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Balto. Transit Co

FATHER
12. Name George F. Wennagel
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah Klaps
15. Birthplace Balto.

16 (a) Informant Miss Maria Krauss
(b) Address 418 Equitable Building-Calvert St.

17 (a) Cremation (b) Date thereof 4/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., MD.

19 (a) — (b) Huntington Williams
(Signature of local registrar)

APR 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 9.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945, to April 21 1945, and that I last saw him alive on 4-21 1945.

Immediate cause of death: Terminal Bronchopneumonia — Duration —
Due to Metastatic carcinoma —
Due to Carcinoma of bladder —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation March 31, 1945
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Stevens Hatch M. D.
Address Church Home Hospital Date signed 4-22-45

X

62814-2 : 3 BALTIMORE CITY HEALTH DEPARTMENT ✓ 62814-2

CERTIFICATE OF DEATH 178a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Windsor Court Apts
(b) Street address 2111 Garrison Blvd.
(c) Hospital or institution: D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Court Apts Blvd 2111 Garrison (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Oscar S. Taylor.

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ida Elizabeth
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/22/1865

8. AGE: Years	Months	Days	If less than one day
80	3	0	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business Retired

FATHER
12. Name John D. Taylor
13. Birthplace N. Y.

MOTHER
14. Maiden Name Mary C. Kugler
15. Birthplace Md.

16 (a) Informant Ida E. Taylor
(b) Address Windsor Ct. Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Baltimore Md

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md

19 (a) APR 23 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1945 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/8
(a) Date of injury 4/22/45 at about 9:00 A.M.
(b) Where did injury occur? 2111 Garrison Blvd
(c) Did injury occur at home, on farm, industrial place, in public place? Windsor Ct. Apts (or work?) No
(d) Means of injury, Illuminating Gas from open burner of stove

23. Signature P. L. Pisani M.D. Medical Examiner.
Date signed 4/24/45

VS 151

628142 628142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5104 Norwood Ave.
(c) Hospital or institution: 28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HOWARD MYERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	217-01-4217

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alma M. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1882

8. AGE: Years	Months	Days	If less than one day
63	2	12	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Comptroller
11. Industry or business Nat'l. Lead Co.

FATHER
12. Name Solomon Myers
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Starr
15. Birthplace Md.

16 (a) Informant Mrs. Alma M. Myers
(b) Address 5104 Norwood Ave.

17 (a) Burial (b) Date thereof 4/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (b)
(Date rec'd by registrar) Registrar

APR 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 9 1945 to Apr 22 1945
and that I last saw h-m alive on Apr. 21 1945

Immediate cause of death Carcinoma-1 pancreas secondary involvement-1 gall bladder — Duration about 6 mo.
Due to
Due to
Other Conditions Secondary anemia. 6 mo.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur ~~about home~~, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Wright M. D.
Address 1220 Harrison Pl. Baltimore
Apr 23/45

G28143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G28143
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 S. Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Folcroft St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maria Boeren

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martienus Boeren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1894.

8. AGE: Years 51 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Holland (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at home.

FATHER
12. Name William Gordon
13. Birthplace Holland

MOTHER
14. Maiden Name Johanna Vander Zaane
15. Birthplace Holland

16 (a) Informant Martienus Boeren (Husband)
(b) Address 433 S. Folcroft St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-45. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern ave. Rd.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) APR 23 1945 (Date received by registrar) (b) Registrar's signature

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20/45, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1945 to 4/20 1945, and that I last saw h alive on 19

Immediate cause of death: Uremia — Duration

Due to Hypertensive Cardio vascular Renal Disease

Due to

Other Conditions One Kidney Present
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Gassaway, M.D.
Address Date signed 4/24/45

G28144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 B

Registered No. G28144

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 166 East St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Doley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1871

8. AGE: Years	Months	Days	If less than one day
73	7	3	hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Richard Doley
13. Birthplace Va.

MOTHER
14. Maiden Name Lyonda Scott
15. Birthplace Va.

16 (a) Informant none
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.

18 (a) Funeral director Joseph G. Locke, Jr.
(b) Address 1364 N. Central Ave

19 (a) Date received APR 23 1945 Huntington Woodmar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1945 to 4/19 1945, and that I last saw h[illegible] alive on 4/18 1945

Immediate cause of death Generalized Carcinomatosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Le. Paul Jenkins

Address Mercy Hosp Date signed 4/19/45

G28145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G28145 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address /
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) [redacted] Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 School St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~[redacted]~~ Clarence Marshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age 1890 years

7. Birth date of deceased (mo., day, yr.) Sept 17-1929

8. AGE: Years 54 | Months 7 | Days 4 | If less than one day hr. - min.

9. Birthplace La Plata Md. Charles Co. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Frank Marshall
13. Birthplace La Plata Charles Co Md

MOTHER 14. Maiden Name Susan Gowo
15. Birthplace La Plata Charles Co Md

16 (a) Informant Effie Bennett
(b) Address 1705 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Cabrary
Location Brookfarm Pa Brooks

18 (a) Funeral director
(b) Address 1463 N. Carey St

19 (a) (Date received by registrar) (b) Registrar

APR 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 1.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1945 to 4/21 1945, and that I last saw him alive on 4/21 1945.

Immediate cause of death Congestive heart failure — Duration

Due to

Due to

Other Conditions Pulmonary tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles D. Cappe M. D.
Address University Hospital Date signed 4/21/45

(over)

TONKS

628146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 F

Registered No. 628146

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilmor & Redwood
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) If dead

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Paca St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bryant Towns

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/17/1945

8. AGE: Years — Months — Days 4 If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Norman Towns
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy Norris
15. Birthplace Balto. Md.

16 (a) Informant Norman Towns (father)
(b) Address 610 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director Chas. H. Foster
(b) Address 512 N. Carrollton Ave.

19 (a) Filed APR 23 1945 (b) Harrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1945, at 1 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1945 to 4-21 1945 and that I last saw him alive on 4-20 1945

Immediate cause of death: Cong'l Lues?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Data but results of autopsy: Not obtainable

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gallatin M.D.
Address Univ. Hosp. Date signed 4/24/45

VS 150

G28147.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G28147.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 West Saratoga
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 West Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY TILGHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife JAMES TILGHMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 22 189?

8. AGE: Years	Months	Days	If less than one day
52	6	26	hr. min.

9. Birthplace BERSMITH, VA.
(Town, county, and state)

10. Usual Occupation HOUSEWORK

11. Industry or business

FATHER
12. Name WM. WRIGHT.
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name ROSIE ?
15. Birthplace VA.

16 (a) Informant ELSIE EDWARDS
(b) Address 325 MOUNT ST.

17 (a) Burial (b) Date thereof 4-23-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 23 1945 (b) Huntington White Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/45 19 at 5:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed 4/19/45

G28148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28148

Registered No. 13 1a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Bruce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Turner

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife Samuel Turner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Middlesex Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaac Reed
13. Birthplace Middle Sex Co., Va.

MOTHER
14. Maiden Name Fannie
15. Birthplace Va.

16 (a) Informant Ollie King
(b) Address 506 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4, 23 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 23 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1945, at 4:25 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 4-19-45

VS 151

G28149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G28149

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.D.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 1626 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Peter Hertford Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1902

8. AGE: Years	Months	Days	If less than one day
42	9		hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Charles H. Dorsey
13. Birthplace Howard County, Md.

MOTHER
14. Maiden Name Carrie Jones
15. Birthplace Howard Co., Md.

16 (a) Informant Hattie Dorsey, sister
(b) Address 1510 W. Lemmon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 24 '45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location.....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Gentzler M.D. Medical Examiner.
Date signed April 21 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G28150

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 S. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 247 S Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Klosicki (Maliszewski)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1903
8. AGE: Years 42 Months Days If less than one day hr. min.
9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Electrician
11. Industry or business
FATHER 12. Name Michael Klosicki
13. Birthplace Baltimore
MOTHER 14. Maiden Name Dora Niering
15. Birthplace Baltimore
16 (a) Informant Michael Klosicki
(b) Address 247 S. Washington St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore
18 (a) Funeral director Fred W Ozaguwski
(b) Address 1930 Eastern Ave.
19 (a) (b)

APR 23 1945
(Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 5:16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to April 22 1945, and that I last saw h[illegible] alive on April 22 1945.

Immediate cause of death
(a) Cardio-Respiratory failure
Due to Pulmonary TB.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 24 hrs. 8 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis J. Levy M.D.
Address 2007 Pratt St Date signed 4/23/45

X

G28151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

Registered No. G28151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 9 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 267 E. Hamburg St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Douglas Talmadge Nickels

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 2/20/45

8. AGE: Years | Months: 2 | Days: 2 | If less than one day: ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Talmadge Nickels
13. Birthplace Kentucky

MOTHER
14. Maiden Name Anna B. Aldridge
15. Birthplace Kentucky

16 (a) Informant Grace Nelson
(b) Address 622 Eastern Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)

(c) Cemetery or crematory Fullerton, Ken.
Location Fullerton, Kentucky

18 (a) Funeral director John F. Wenning Sr.
(b) Address 711 Light St.

19 (a) APR 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945, at 9:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Acute Meningitis - Streptococcus

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Wheeler M.D. Medical Examiner.
Date signed 4-23-45

VS 151

G28152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54B

Registration No. G28152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Orleans St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME David Kyle Wellis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: —
6 (b) Name of husband or wife: —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Nov 30th 1934
8. AGE: Years 10 | Months 4 | Days 22 | If less than one day ..... hr. ..... min.
9. Birthplace Jenkins Ky (Town, county, and state)
10. Usual Occupation
11. Industry or business School

FATHER
12. Name Emery D. Willis
13. Birthplace Va

MOTHER
14. Maiden Name Hazel Dingus
15. Birthplace Va

16 (a) Informant Mrs Hazel Wellis
(b) Address 1927 Orleans St
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory
Location Fleming, Kentucky Ulrich Funeral Home
18 (a) Funeral director
(b) Address 2004 Orleans St
19 APR 23 1945 (Date rec'd by registrar) Huntington, W. Va. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 5 10 PM
21. I certify that death occurred on the date above stated; that I attended deceased from April 1st 1945 to April 22nd 1945, and that I last saw him alive on April 22nd 1945:

Immediate cause of death	Duration
Bronchopneumonia	?
Paralysis	
Due to Cerebellar Tumor (malignant)	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. J. Jenkins M. D.
Address 100 N. Mulberry Date signed 4/23/45

G28153

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G28153 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2833 N. Howard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Don't

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Blimberg (BLIMBERG)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1867

8. AGE: Years	Months	Days	If less than one day
77	5	26	hr. min.

9. Birthplace Latvia
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Walter E. Bloomberg
(b) Address 1609 Kingsway

17 (a) Burial (b) Date thereof April 24 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lynnewood Gdns
Location Balto Md.

18 (a) Funeral director Welsh Funeral Home
(b) Address 200 E Orleans

19 (a) APR 23 1945 (b) Huntington Williams, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Sobieski M.D.
Medical Examiner.
Date signed 4/23/45

VS 151

G28154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28154
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 185 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Sheffield

3 (b) If veteran, name war

3 (c) Social Security Account No. 479-09-0301

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs Velma Sheffield
6 (c) If alive, give age years
Nee Burnett

7. Birth date of deceased (mo., day, yr.) 9/3/13

8. AGE: Years 31 | Months 7 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Arkansas (Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Layne Atlantic Co. Norfolk Va

FATHER
12. Name Joseph Sheffield
13. Birthplace Canada

MOTHER
14. Maiden Name Annie Simpson
15. Birthplace Arkansas

16 (a) Informant Mrs. Velma Sheffield
(b) Address Box 185 - Glen Burnie Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 23, 1945 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Mem.
Location Glen Burnie, Md

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Filed 1945 (Date rec'd by registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1945 at 2 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1945 to 4/21 1945; and that I last saw h alive on 4/21 1945

Immediate cause of death Respiratory failure — Duration

Due to Tuberculous meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/18/45

Major findings of operation: Cranial trephine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J. Rolfes M. D.

Address Date signed 4/25/45

X

G28155 3 Helminiak

BALTIMORE CITY HEALTH DEPARTMENT

Helminiak CERTIFICATE OF DEATH 13B

G28155 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Broadway

(c) Hospital or institution: Church Home & Hosp. 1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore Md.

(c) City or town 2938 Elliott St.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2938 Elliott St.
(If rural give location)

(e) Citizen of foreign country? [illegible] No (Yes or No)
If yes, name country [illegible]

3 (a) FULL NAME John Helminiak (or) Helmick (HELMICK)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-3079

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife [illegible] Helminiak

6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) 5-4-1894

8. AGE: Years 50 | Months 11 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Ship fitter

11. Industry or business Ship Building

FATHER 12. Name Frank Helminiak

13. Birthplace Poland

MOTHER 14. Maiden Name Not known

15. Birthplace Poland

16 (a) Informant John Helminiak

(b) Address 2938 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem.

Location Dundalk Ave.

18 (a) Funeral director Stephan Fialkowski

(b) Address 1900 S. Kenwood Ave

19 (a) 4-23-1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1945 to 4-20 1945 and that I last saw h[illegible] alive on 4-20 1945

Immediate cause of death Lobular pneumonia — Duration

Due to Tuberculosis (pulmonary)

Due to

Other Conditions Tuberculosis (pulmonary) Chronic alcoholism

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation Acute Lobular pneumonia pulmonary tuberculosis

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature James B Lockfield M. D.

Address Church Home & Hosp. Date signed 4-20-45

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G28156
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Co. RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rolling Road (Number and Street or Location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Patrick

3 (a) FULL NAME Janice LEE Espey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1942

8. AGE: Years	Months	Days	If less than one day
2	6	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Harry Catton Espey
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marvel
15. Birthplace Baltimore

16 (a) Informant Harry E. Espey
(b) Address Rolling Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Wm. Boob Sr
(b) Address 1217 St Paul

19 (a) APR 23 1945 (Date received by registrar) (b) Huntington Hillsdale Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/1945 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchio-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dorothy B. McNeely, Medical Examiner.
Date signed 4/23/45

G28157 — BALTIMORE CITY HEALTH DEPARTMENT — G28157

CERTIFICATE OF DEATH V 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 Abbotston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Abbotston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Virginia Gilligan

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Martin Gilligan (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1878

8. AGE: Years 66 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER 12. Name Lafayette Riordan
13. Birthplace Unknown

MOTHER 14. Maiden Name Virginia Riordan
15. Birthplace Va.

16 (a) Informant Pauline Engenfelder
(b) Address 1524 Abbotston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Co. Md.

18 (a) Funeral director Wilhom & Dyer
(b) Address 1214 E. Baltimore St

19 (a) Date received by registrar APR 23 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 4 a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945 to April 22 1945 and that I last saw her alive on April 22 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Diabetes	10 yrs
Due to Myocardio Nephrosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred A. Emmanuel M. D.

Address 2858 Harford Date signed 4/24/45

G28158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G28158 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N Greene St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Heimiller

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1872

8. AGE: Years	Months	Days	If less than one day
73.	2	24	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation non
11. Industry or business

FATHER
12. Name Henery Heimiller
13. Birthplace

MOTHER
14. Maiden Name Louisa Kane
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Lyon Inc
(b) Address 1210 Eutaw St

19 (a) APR 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1945, at 10-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945, to April 22 1945, and that I last saw him alive on April 21 1945.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Mitral Stenosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Gill Hall M. D.
Address 1631 E. North Ave Date signed Apr 23 45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G28159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Lawrence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Richard Randall

3 (b) If veteran, name war 2
3 (c) Social Security Account No. None

4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife S
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 28, 1944

8. AGE: Years	Months	Days	If less than one day
	5	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER 12. Name Woodrow Randall
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Womack
15. Birthplace Va.

16 (a) Informant Mary Randall
(b) Address 1509 Lawrence St

17 (a) Burial (b) Date thereof 4/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelso
(b) Address 1303 Pressman St

19 (a) APR 23 1945 Registrar
(Date accepted by Registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 45 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dead when first seen 19 to 19 and that I last saw h alive on 19

Immediate cause of death Pneumonia, Bilateral adrenal hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Goldstein
Address Univ. Hosp. Date signed 4/21/45 M.D.

Howard J. Goldstein, M.D.

VS 150

628160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 479

628160
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Mt. Royal Ave.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Mt. Royal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA AUGUSTA RIDGELY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dr. Vernon N. Ridgely
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 21, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	0	hr. min.

9. Birthplace: Buckeystown, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Rev. D. Monroe Browning
13. Birthplace: Libertytown, Md.

MOTHER
14. Maiden Name: Malvina V. Davis
15. Birthplace: Sandy Springs, Md.

16 (a) Informant: Dr. Vernon N. Ridgely
(b) Address: 1503 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 25 1945

Huntington

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1945 at 10:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17th 1945 to April 21 1945 and that I last saw h alive on April 21 1945.

Immediate cause of death: Carcinoma of lung — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [illegible] M. D.
Address: Medical Arts Bldg. Date signed: 4-24-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

628161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GEORGE JACOB HOEFLICH, SR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Hoeflich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1862

8. AGE: Years 82 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Collector

11. Industry or business Self

FATHER
12. Name Adam Hoeflich
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Gable
15. Birthplace Germany

16 (a) Informant Mrs. Josephine Hoeflich
(b) Address 2019 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1945, at 3:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar.1, 1945, to Apr.21, 1945, and that I last saw him alive on Apr.21, 1945.

Immediate cause of death	Duration
Cardiac Insufficiency	2 mon.
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp, M. D.
Address 3030 Edmondson Avenue Date signed 4/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28162 JL. 93213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937

G28162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Old S. Penna St~~ (If rural give location)
(e) Citizen of foreign country? Virginia (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Beebe (Mary Schwartz Beebe)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles E. Beebe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 26, 1903

8. AGE: Years 41 | Months 4 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace: Maryland, Baltimore
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Conrad Schwartz
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Susie Koontz
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24, 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Miller & Lamborn
(b) Address: 1003 W. Baltimore St.

19 (a) (Date received by Registrar) (b) APR 23 1945 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1945, at 11.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20th 1945 to Apr. 21 1945, and that I last saw h~~im~~er alive on Apr. 21 1945.

Immediate cause of death: uremia (Cause unknown)

Duration: ?

Due to:

Due to:

Other Conditions: Hypertensive Cardio Vascular disease complicated
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: only head obtained - this neg.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: C. E. Penn M.D.
Address City Hosp. Date signed 4/24/45

628163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

628163 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Home~~
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 ~~days~~ 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Lyndhurst St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs. Carrie E. Saunders~~ Carrie Esther Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William M. Sanders
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) January 21, 1874

8. AGE: Years	Months	Days	If less than one day
71	3	1	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Washington Marchant
13. Birthplace Mathews County, Va.

MOTHER
14. Maiden Name Ada Lyon
15. Birthplace Petersburg, Va.

16 (a) Informant Mr. William M. Sanders
(b) Address 313 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Emile Amoss
(b) Address 4510 Liberty Heights Ave.

19 (a) ..... (Date rec'd by registrar) (b) ..... Huntington Williams, M.D. Registrar

APR 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1945, to April 22 1945, and that I last saw her alive on April 22 1945.

Immediate cause of death Pulmonary edema,
Due to Heart failure
Due to Hypertension - Arteriosclerotic and Chronic cardiac disease
Other Conditions Uremia; Carcinoma of cervix uteri
(Include pregnancy within 3 months of death)

Duration

Date of operation 4/14/45
Major findings of operation: Recurrent ca of cervix in old cervical scar
of autopsy: Heart failure, arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Percy T. Fitzhugh M. D.
Address University Hospital Date signed 4/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28164
FL - 93199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30E

G28164
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Newkirk St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John S. Downey

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-8273

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Sep. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	7	29	hr. min.

9. Birthplace Md. Rock Hall
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name ? John Downey
13. Birthplace ? Rock Hall, Md.

MOTHER
14. Maiden Name ? Miss Perry
15. Birthplace ? Rock Hall, Md.

16 (a) Informant Corp. Joseph Downey
(b) Address 4940 Eastern Ave. 317 E. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Niles Amoroso
(b) Address 1003 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 21 1945, at 5.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1945, to April 21 1945, and that I last saw him alive on April 21 1945.

Immediate cause of death Cerebrovascular accident

Due to

Due to

Other Conditions Cystic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy no post

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Perry Jr. M.D.
Address City Hosp. Date signed 4/24/45

83a

G28165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28165 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital of last. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 E. 20½ St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George E. Waters

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-29-90

8. AGE: Years	Months	Days	If less than one day
54	4	24	..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Waters
13. Birthplace md.

MOTHER
14. Maiden Name Laura Buchanan
15. Birthplace md

16 (a) Informant Bertha Waters
(b) Address 328 E. 20½ St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location .....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) APR 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 1:00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration, Pulmonary Edema
Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 23 1945

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

628166

CERTIFICATE OF DEATH ✓ 83a 628166

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3620 Kimble Rd. St. 3 Ward)

Length of residence in city or town where death occurred ....yrs. ....mos. ....ds. How long in U. S. If of foreign birth? ....yrs. ....mos. ....ds.

2. FULL NAME Bennie Aydett Burfoot

If U. S. Veteran specify WAR .....

(a) Residence: No. 3620 Kimble Road St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Noah Burfoot

6. DATE OF BIRTH (month, day, year) May 16, 1864

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	11	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Camden Co. N. C.

FATHER

13. NAME Abner Aydett

14. BIRTHPLACE (city or town) (State or country) Camden Co. N. C.

MOTHER

15. MAIDEN NAME Clotilda Sant.

16. BIRTHPLACE (city or town) (State or country) Camden County N. C.

17. INFORMANT Mrs. Wm. P. Heron

(Address) 3620 Kimble Road

18. BURIAL, CREMATION, OR REMOVAL

Place Edgewood Cem't Date 4-24 19 45

19. UNDERTAKER Loring Byers

(Address) 5005 Park Heights Ave

20. FILED ..... 19.....

Registrar.

APR 23 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4-21 3:20 P.M. 19 45

22. I HEREBY CERTIFY, That I attended deceased from Nov 16 1944 to 4-21 1945

I last saw her alive on 4-21 1945 Death is said to have occurred on the date stated above, at 7:40 P m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Cerebral hemorrhage	5 hrs

Other contributory causes of importance:

Arteriosclerosis

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) Kenneth H Owens M. D.

(Address) 3611 Kimble Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628167

TN. 92738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

Registered No. 628167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Spangler Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Dennis Sainsbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6th, 1941

8. AGE: Years 4 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: John Sainsbury
13. Birthplace Pa.

MOTHER
14. Maiden Name: Margaret Singer
15. Birthplace Pa.

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 24/45 (month) (day) (year)
(c) Cemetery or crematory: Harley County N J
Location: New Jersey

18 (a) Funeral director: Wardian Cook Inc.
(b) Address: 417 St. Paul St. Baltimore Md.

19 (a) APR 23 1945 (Date filed by Registrar)

Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd, 1945, at 10;00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23 1945 to Apr. 23 1945 and that I last saw h is alive on Apr. 23 1945

Immediate cause of death	Duration
Heart failure:	
Due to Rheumatic heart disease	2 Mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh W. Jocelyn M.D.

Address B.C.H. Date signed 4/24/45

G28168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28168 Registered No.

TN. 19976

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-3- 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Morrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th, 1872

8. AGE: Years 72 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Morrison

FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden Name Julia Norfolk

MOTHER 15. Birthplace Baltimore

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)

(c) Cemetery or crematory

Location Washington D. C.

18 (a) Funeral director James F. Ryan Inc

(b) Address 317 Pa ave SE. Wash, D.C.

19 (a) Huntington Williams (Signature of registrar)

APR 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23rd 1945 19 , at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3-37 19 to Apr. 23 19 45 and that I last saw him alive on Apr. 23 19 45

Importante cause of death	Duration
Carcinoma of esophagus with metastasis.	7
Pneumonia	7 days
Due to	7
Other Conditions Arteriosclerotic heart disease.	7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. M. Pfeiffer M. D.

Address Balt City Hosp. Date signed 4-23-45

G28169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28169 / 108

Registered No. G28169

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 S. 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Nelson Swann

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-12-7546

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Elizabeth Blaney Swann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Ruthsburg, Md. (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business Ship Yard

FATHER
12. Name Thomas D. Swann
13. Birthplace Ridgely, Md.

MOTHER
14. Maiden Name Bertha E. Rutter
15. Birthplace Crumpton, Md.

16 (a) Informant Thos. D. Swann
(b) Address Queenstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25-45 (month) (day) (year)
(c) Cemetery or crematory Chesterfield
Location Centreville Maryland

18 (a) Funeral director Dalton Bros
(b) Address Centreville Maryland

19 (a) Apr 23 1945 by registrar (b) Huntington Williams M.D.

APR 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed April 23 1945

(over)

G28170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28170

Registered No. 52B

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary P. Naughton (Mary P. Naughton)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1868

8. AGE: Years 76 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace New Port R.I.
(Town, county, and state)

10. Usual Occupation Retired Nurse

11. Industry or business

FATHER
12. Name Michael Naughton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary N. Drury
15. Birthplace Ireland

16 (a) Informant Miss Anna T Naughton
(b) Address 1623 N. Caroline Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25, 1945 (month) (day) (year)
(c) Cemetery or crematory St Mary's, Annapolis Md.
Location Annapolis Md.

18 (a) Funeral director B. L. Hopping
(b) Address Annapolis, Md.

19 (a) Date received by registrar APR 23 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-1944, to 4-21-1945. and that I last saw her alive on 4-20-1945

Immediate cause of death: Carcinoma Bladder — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Lytle M. D.

Address 2802 Harford Rd Date signed 4-23-45

X

G28171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G28171 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 Wilhelm St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Wilhelm St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Prince

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Charles Prince

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25-1858

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	7	27		

1868

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Adolf.
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Husk
15. Birthplace Maryland.

16 (a) Informant George Prince
(b) Address 1018 Ashland Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24-1945 (month) (day) (year)
(c) Cemetery or crematory Pere Cathedral
Location Baltimore Md.

18 (a) Funeral director George L. Fahnestock
(b) Address 2101 Frederick Ave.

19 (a) Apr 23 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1945 to Apr 21 1945, and that I last saw h. alive on Apr 21 1945.

Immediate cause of death	Duration
Toxaemia	5 days
Due to Intestinal Obstruction	6 Days
Due to Bronchial Pneumonia	3 Wks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Kalen

Address 2027 W. Pratt St. Date signed 4/24/45

G28172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28172

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Natalie Ballou

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March [illegible] 1869

8. AGE: Years 76 | Months - | Days 25 | If less than one day: hrs. ... min.

9. Birthplace Virginia [illegible]ville (Town, county, and state)

10. Usual Occupation Retired School Teacher

11. Industry or business

FATHER
12. Name Charles A. Ballou
13. Birthplace Halifax Co-Virginia

MOTHER
14. Maiden Name Arthur Talley
15. Birthplace Virginia

16 (a) Informant Joseph W. Bladey
(b) Address Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24-45 (month) (day) (year)
(c) Cemetery or crematory Richmond Va.
Location Virginia

18 (a) Funeral director John C. Miller Inc.
Address 2405 E. Oliver St.

19 (Date received by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1945, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9-45 19... to 4-23-45 19..., and that I last saw her alive on 4-23-45 19...

Immediate cause of death: Terminal Bronchopneumonia — Duration:

Due to: Coronary insufficiency

Due to: Arteriosclerotic cardiovascular Disease

Other Conditions: Angina pectoris

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Grady M. D.
Address 1416 Linwood Ave. Date signed 4-24-45

VS 150

G28173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28173

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susanna C. Luttkehusen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late Frank J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th 1863

8. AGE: Years 81 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Benjamin F. Cooper
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Martha M. Lee
15. Birthplace Baltimore Md

16 (a) Informant Mr. Benjamin F. Luttkehusen
(b) Address 935 West Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4439 Belair Road

18 (a) Funeral director John L. Cowan & Son
(b) Address 901-03 Baltimore St.

19 APR 24 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20th 1945, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 19 , to 4/20 1945 and that I last saw her alive on 4/20 1945.

Immediate cause of death	Duration
Cardio-vascular Hypertensive disease	5 Yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L. Todd

Address 735 N. Fulton Ave. Date signed 4/24/45 D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G28174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 N Lonsdale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N Lonsdale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Albert Earl Clough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emelia L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1889

8. AGE: Years 55 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Boat-Mover

11. Industry or business Bethlehem Steel

FATHER
12. Name Albert Clough
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Effie Jane Cox
15. Birthplace Cecil Co Md

16 (a) Informant Mrs Mary Cunningham
(b) Address 1610 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 217 W Saratoga St

(a) Filed APR 24 1945 (Registrar) (b) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 22 1945, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to April 22 1945 and that I last saw h[illegible] alive on Apr. 19 1945

Immediate cause of death Cancer of Throat — Duration 16 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E. Wilson
Address 3 W. Biddle Date signed Apr. 23. 45 M. D.

X

VS 150

G28175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G28175

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3410 N Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3410 N Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Henderson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah Henderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1892

8. AGE: Years 52 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and State)

10. Usual Occupation Cast Market Master

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Hannah E Henderson
(b) Address 3401 Elmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Wilhom Co Inc
(b) Address 1317 St Paul St

APR 24 1945 (Date rec'd by registrar)

(b) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to April 23 1945 and that I last saw h[illegible] alive on Feb 2 5 1945

Immediate cause of death	Duration
Congestive Heart Failure	1 mo.
Due to Hypertensive Cardiovascular Renal Disease.	?
Due to	
Other Conditions None (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millom E Lohman M. D.
Address 5013 Park Heights Ave Date signed 4-23-45

X

G28176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G28176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 3001 Belmont ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Tyler Aldridge
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife James E Aldridge
6 (c) If alive, give age; if dead, how long married
7. Birth date of deceased (mo., day, yr.) Feb 1885

8. AGE: Years	Months	Days	If less than one day
60	6	29	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Marion R Tyler
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Helen Stein
15. Birthplace Balto Md

16 (a) Informant James E Aldridge
(b) Address Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Pilkerton & Lowe
(b) Address 1217 N Fremont St

19 (a) APR 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1945 at 1.45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1945 to 4/23 1945
and that I last saw her alive on 4/23 1945
Immediate cause of death Uremia

Duration

Due to Carcinoma of Cervix

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Guy M. D.
Address Univ Hosp Date signed 4/25

E. Guy - M.D.

G28177 G28177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1602 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 hight St.
(c) Hospital or institution: So. Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town White Marsh Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 46
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joy Lou Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Carnes O. Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Ina Joyce Odom
15. Birthplace N. C.

16 (a) Informant Carnes O. Brown
(b) Address White Marsh Md.

17 (a) Burial (b) Date thereof Apr 24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave

18 (a) Funeral director John W. Cuttshall & Sons
(b) Address 610 Eutaw Place

19 (a) 4-24 1945 (b) Attesting for Williams, M.P.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1945; at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1945 to 4-23 1945 and that I last saw h[illegible] alive on 4-23 1945.

Immediate cause of death	Duration
(a) Atelectasis	
Due to Aspiration of amniotic fluid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Arduiger M.D.
Address 1213 hight St. Date signed 4-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G28178
TN. 46100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 3/13 (mc)

Registered No. G28178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 5- 9-22 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (No Home)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mannie Rustin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex emale

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25th 1873/82

8. AGE: Years 6 2 72 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hillary Rustia
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie Backous
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lenyse M. Holland
(b) Address 1631 Druid Hill Ave

APR 24 1945 (Date Rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1945 19 , at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29-39 19 , to 4-21-45 19 , and that I last saw her alive on Apr. 21 19 45

Immediate cause of death Cardiac failure

Duration

Due to

Due to

Other Conditions Chronic glomerulo nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Examination

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 4-22-45

VS 199

628179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

628179 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymond
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Bellwood Ave
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sherman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Martin B. Sherman
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 22, 1905

8. AGE: Years	Months	Days	If less than one day
39	9	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Weber G Lippy
13. Birthplace Maryland

MOTHER
14. Maiden Name Myrtle M. ?
15. Birthplace Maryland

16 (a) Informant Martin B. Sherman
(b) Address 1236 Bellwood Ave

17 (a) Burial (b) Date thereof April 24 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Thomas J. Donovan
(b) Address 3615-17 Eastern Ave

19 (a) APR 24 1945 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945 to April 21 1945, and that I last saw her alive on April 21 1945.

Immediate cause of death Cerebral Hemorrhage Status arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Russell W. Baldwin

Address West Baltimore General Hosp. Date signed 4/25/45 M. D.

X

628180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

628180
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 N. Fulton Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE ROE

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John E. Roe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/1877

8. AGE: Years	Months	Days	If less than one day
67	5	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Ault
15. Birthplace Germany

16 (a) Informant Mr. John E. Roe
(b) Address 1724 N. Fulton Ave.

17 (a) Burial (b) Date thereof 4/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 24 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 19 45 at 9:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1944 to April 22 1945
and that I last saw him alive on April 22 1945

Immediate cause of death Cardiac failure
Due to Hypostatic congestion
Due to Myocardial Softening

Duration
1 Year
2 da.
3 da.

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1202 St Paul St Date signed 4/24/45 M. D.

G28181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G28181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3912 Dorchester Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Dorchester Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Donald Burns

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline J. Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/3/1893

8. AGE: Years 52 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Brooklyn, N. Y.
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Wm. P. Burns
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Katherine Mulstead
15. Birthplace Laurel Md

16 (a) Informant Mrs. Pauline Burns
(b) Address 3912 Dorchester Rd.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md

18 (a) Funeral director Wm. J. Sirkener & Son
(b) Address Balto. Md

19 (a) APR 24 1945 (Date rec'd by registrar) (b) [illegible] Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1945 at 10:10 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCullough Medical Examiner.
Date signed 4/24/45

VS 151

G28182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 ✓

Registered No. G28182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Harris.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Harris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): January 20, 1845
8. AGE: Years 50 | Months 3 | Days - | If less than one day hr. min.
9. Birthplace A. A. County, Md. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Heintzman
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Cynthia Pulley
15. Birthplace A. A. County, Md.

16 (a) Informant Noah Harris (son)
(b) Address 637 N Carey St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
19 (a) (Date rec'd by registrar) APR 24 1945 (b) (Registrar) Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at 8 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1945 to 4/20 1945 and that I last saw h[illegible] alive on 4/20 1945
Immediate cause of death Unknown
Possible Coronary Occlusion — Duration
Due to Deabetes Mellitus & Generalized Arteriosclerosis — Diabetes Mellitus 7 years
Due to Shock
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature RC Lonergan
Address Union Hospital Date signed 4/20/45 M. D.

X

G28183

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G28183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 152 W. Hamburg st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Etta Powell Dawkins (Wilson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~ Seperated

6 (b) Name of husband or wife unknown

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-24-1899

8. AGE: Years 45 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
12. Name James Powell.
13. Birthplace N. C.

MOTHER
14. Maiden Name Francis ?
15. Birthplace N. C.

16 (a) Informant Mary Huggins
(b) Address 102 Canal Ct apt. B-3.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 4 24 45 (month) (day) (year)
(c) Cemetery or crematory Danville Cem
Location Danville Virginia

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

APR 24 1945 (a) Entered by registrar Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945, at 11 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1945 to 4/22 1945, and that I last saw her alive on 4/22 1945

Immediate cause of death Diabetic acidosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Woodland, M. D.
Address Provident Hospital Date signed 4/23/45

X

G28184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28184

JO #93219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Waldo Ct. (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lindsey Macon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Rosa
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1911

8. AGE:	Years	Months	Days	If less than one day
	33	7	-7-	..... hr. ..... min.

9. Birthplace Louisiana (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name William Macon
13. Birthplace Georgia

MOTHER
14. Maiden Name Mamie ?
15. Birthplace Louisiana

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location .....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave. (b) Huntington Williams, M.D. Registrar

APR 24 1945 (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945, at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20, 1945 to Apr. 22, 1945, and that I last saw h im alive on Apr. 22, 1945.

	Duration
Immediate cause of death Pontiac unsuccessful?	?
Due to	
Due to	
Other Conditions Lobar pneumonia Pulmonary TB? TB peritonitis? (Include pregnancy within 3 months of death)	1 week

Date of operation .....
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
(f) Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 4-23-45

95c

628185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

628185 ✓ 46E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2040 Braddish Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County **
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 Braddish Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora U. Ellsberry

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward F. Ellsberry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1879

8. AGE: Years 65 | Months 6 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Nathan E. Underwood
13. Birthplace Alabama

MOTHER
14. Maiden Name Julia A. Huey
15. Birthplace Alabama

16 (a) Informant Miss. Louise Ellsberry
(b) Address 2040 Braddish Ave. 16

17 (a) Burial (b) Date thereof April 25, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

APR 24 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH April 22, 1945, at 3:31 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945 to April 22 1945, and that I last saw h[illegible] alive on April 21 1945.

Immediate cause of death	Duration
Intestinal obstruction	
Due to Carcinoma	7 day
Due to Carcinoma general	
Head Lungs and Intestines	1 year
Due to and general cachexia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April 1944

Major findings of operation: Carcinoma

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert E. Zapp M. D.

Address 3048 N. Howard St. Date signed 4/23/45

VS 150

X. Baltimore 16 Md.

628186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115C

628186 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 662a Altamont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anne Hobbs (Hobbs)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	(S)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/29/1941

8. AGE: Years	Months	Days	If less than one day
4	1	22	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard Hobbs
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Gray
15. Birthplace Maryland

16 (a) Informant Mrs. Hazel V. Ensor
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Geo. W. Bailey
(b) Address Fulton & Fayette

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

APR 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1945 to April 21 1945 and that I last saw her alive on April 21 1945

Immediate cause of death: Subarachnoid Hemorrhage — Duration

Due to: Status Epilepticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 20, 45

Major findings of operation: C & A

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H W Steer for O'Elias M.D. M. D.

Address St. Agnes Hosp Date signed 4/21/45

X

G28187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28187 Registered No. 3017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31 St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 7½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 N. 13 St., Phila. Pa.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Duncan Nathaniel Yearwood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Rose Simms
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) April 24, 1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
45	11	28		

9. Birthplace British West Indies
(Town, county, and state)
10. Usual Occupation Chief Steward
11. Industry or business Sea-faring

FATHER
12. Name John Yearwood
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Silina Padmore
15. Birthplace British West Indies

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia Pa.

18 (a) Funeral director Joseph L. Gourley
(b) Address 804 N. Carrollton Ave.

19 (Date received by local registrar) APR 24 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 7:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1943, to April 22 1945, and that I last saw him alive on April 22 1945.

Immediate cause of death	Duration
Myocardial hypertrophy and dilation; coronary sclerosis	Unk.
Due to Arteriosclerotic heart disease and hypertensive cardio-vascular disease; arteriosclerosis, general; renal arteriosclerosis.	Unk.
Due to	
Other Conditions Cirrhosis of liver; Encephalomalacia due to hemorrhage	

(Include pregnancy within 3 months of death) (over)

Date of operation
Major findings of operation: no major operation
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones
Benjamin F. Jones M. D.
Address Balto., 11, Md. US Marine Hospital
Date signed 4/23/45

131a

G28188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G28188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Greenmount ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F Shaneybrook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Thomas J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1864

8. AGE: Years 80 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore County (Town, county, and state)

10. Usual Occupation none - Housewife

11. Industry or business

FATHER 12. Name Lewis Thompson

FATHER 13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name ? Fales

MOTHER 15. Birthplace Balto. Co. Md

16 (a) Informant Mrs. E. H. Kohel

(b) Address 2430 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 27 1945 (month) (day) (year)

(c) Cemetery or crematory Jessops

Location Sparks, Md.

18 (a) Funeral director Landon M. Burpo

(b) Address Sparks, Md.

19 (a) APR 21 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 1945 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1945 to 4/24 1945, and that I last saw her alive on 4/23 45.

Immediate cause of death: Coronary Occlusion — Duration

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St Josephs Hospital Date signed 4-24-45

X

G28189

TN. 58614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28189

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) ← 7-19 | 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home 422 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME W. Annie Bull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife James H. Bull (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9th. 1849

8. AGE: Years 96 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore - (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name William Forrest
13. Birthplace Va.

MOTHER
14. Maiden Name Harriet Martin
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto -

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

APR 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23rd. 1945 19 , at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 19 1940 to Apr. 23 19 45 and that I last saw h or alive on Apr. 23rd 19 45

Immediate cause of death Cerebral Hemorrhage — Duration 1 hr.

Due to Arteriosclerosis — 7

Due to — 7

Other Conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Baltimore, Md. Date signed 4-23-45

VS 180

G28190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1559

Registered No. G28190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Barton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Dupen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed, or divorced.~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 1945

8. AGE: Years | Months | Days | If less than one day: 1 hr. 20 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Alex Dupen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Wanda Krupnik
15. Birthplace Baltimore

16 (a) Informant Alex Dupen
(b) Address 2706 Barton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Md

18 (a) Funeral director F W Ozazewski
(b) Address 1900 Eastern Ave

APR 24 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1945 to April 24 1945 and that I last saw him alive on April 24 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hruska M. D.

Address St. Joseph's Hosp. Date signed 4/24/45

VS 150

G28191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

G28191
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -11-
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Wilson Collins

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Luther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1899

8. AGE: Years	Months	Days	If less than one day
46	3	22	hr. min.

9. Birthplace West. Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER	12. Name Major Wilson
	13. Birthplace Va.
MOTHER	14. Maiden Name unobtainable
	15. Birthplace

16 (a) Informant Luther Collins
(b) Address 1219 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory Draper
Location North Carolina
18 (a) Funeral director Leg. B. Kelsey
(b) Address 1303 Pressman St

APR 24 1945 Huntington Williams M.R. Registrar
(Date rec'd by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to 4-23 1945, and that I last saw h[illegible] alive on 4/20 1945.

Immediate cause of death

	Duration
(a) Pulmonary embolism	11 Da
Due to Nephritis,	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher
Address [illegible] Date signed 4/24/45
M.D.

X

G28192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G28192 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103-W-39th St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103-W-39-St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Esther Still Lemoine

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife: John H. Lemoine.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-12-1866

8. AGE: Years 78 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER
12. Name: William C. Still
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Virginia Branham
15. Birthplace: Virginia

16 (a) Informant: Mrs Esther L. Johnson Daughter
(b) Address: 103-W-39-St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr-24-45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville

18 (a) Funeral director: Edward Maxwell
(b) Address: 608 W. Baltimore

19 (a) APR 24 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 2:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to April 22 1945, and that I last saw him alive on April 22 1945;

Immediate cause of death: Cancer of intestinal tract with metastases to liver.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

Duration: Not known

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John H. Johnson
Address 103 W. Calvert St Date signed April 22

VS 150

G28193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 1310

G28193 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409-E. Chase St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Michael Gannon (MICHAEL JAMES GANNON)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Ann Gannon

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 10, 186-

8. AGE: Years 82 | Months 10 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Boston Ireland
(Town, county and state)

10. Usual Occupation Garage Owner

11. Industry or business

FATHER 12. Name Thomas Gannon

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Delaney

15. Birthplace Ireland

16 (a) Informant John T. Gannon

(b) Address 1196 - Ensor St. (Son)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-25-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE.

19 (a) APR 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945 to 4/21 1945; and that I last saw h. alive on 4/21 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Cerebrovascular C.V. renal disease.	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry F. Rosen M. D.

Address Date signed 4/21/45

VS 150

X

G28194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G28194

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Broadway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas S. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie Shanrahan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1872

8. AGE: Years 72 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bro. R.R.

FATHER
12. Name James Carroll
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Amelia Rollins
15. Birthplace Baltimore Md

16 (a) Informant Jennie Carroll
(b) Address 1512 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Baltimore Md

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

19 (a) APR 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1945 at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1945 to 4-23 1945 and that I last saw [illegible] alive on 4-23 1945

Immediate cause of death: Uremia — Duration

Due to: Benign Prostatic Hypertrophy

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D. Robertson M. D.
Address St Josephs Hosp. Date signed 4-23-45

X

G28195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G28195 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Brent St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Brent St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rideout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Virginia

MOTHER
14. Maiden Name Arbella Reed
15. Birthplace Va.

16 (a) Informant Pauline Ridout
(b) Address 1408 Brent St

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Balto. Md

18 (a) Funeral director Archibald A. Gaddis
(b) Address 2101 Mc Culloh St

19 (a) APR 24 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 19 45 at 9 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary TB

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. P. Schneider M.D.
Medical Examiner.
Date signed 4/21/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G28196
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town 632 E. 4th (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Balto Co Highway Dept~~ (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1883

8. AGE: Years 60 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Balto. Ship Yard

FATHER
12. Name John J. Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Delia Flaherty
15. Birthplace Ireland

16 (a) Informant Miss Kelly

(b) Address 632 E. 4th Apt. 2 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Location Old Frederick Rd.

18 (a) Funeral director John J. Mahan

(b) Address 3010 E. Baltimore St.

19 (a) APR 24 1945 (Date received by Registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1945, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1945 to 4-23 1945 and that I last saw him alive on 4-23 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Agranulocytosis	
Due to	
Other Conditions Cirrhosis Liver, ulcer cornea.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Robertson M. D.

Address St Josephs Hosp Date signed 4-23-45

76a

G28197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28197 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1845 W. Balto St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 W. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Augusta M. King

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John R. King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1855

8. AGE: Years 89 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Ryon
13. Birthplace Md

MOTHER
14. Maiden Name Susan Frey
15. Birthplace Md

16 (a) Informant Mrs Eva King
(b) Address 1845 W Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo. E. Boyd & Son
(b) Address 15 & 17 Hollins St

19 (a) APR 24 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945; at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6 1944 to 4/23 1945, and that I last saw h[illegible] alive on 4/22 1945.

Immediate cause of death: Myocardial degeneration — Duration (?)

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Boyd
Address 1905 W Baltimore Date signed 4/25/45

X

G28198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28198

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Guilford ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Guilford ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Irene Darr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1862

8. AGE: Years 82 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Franklin Davis
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Herbert
15. Birthplace Md

16 (a) Informant Mrs. David Darr
(b) Address 1717 Guilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-45 (month) (day) (year)
(c) Cemetery or crematory Holy Ghost Cem
Location Issue Md

18 (a) Funeral director Hunt-Reyer
(b) Address Waldorf Md

19 (a) APR 24 1945 (Date rec'd by registrar) Huntington Williamson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24/ 1945, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/ 1945, to 4/24 1945, and that I last saw h— alive on 4/24 1945

Immediate cause of death Myocardial Infarction — Duration 2 da

Due to Cerebral Hemorrhage — 2 da

Due to Hypertension — 2 yr

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 12025 St Paul St Date signed 4/25/45

VS 3

G28199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G28199 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution: Gen'l Herman Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S Athol Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie O. Mylander

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife late Henry T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1855

8. AGE: Years	Months	Days	If less than one day
89	7	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Eli Kroegle
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Smith
15. Birthplace Maryland

16 (a) Informant Gen'l Herman Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Ave.

18 (a) Funeral director Harry H. Wilkes
(b) Address 401 Edmondson Ave.

19 (a) APR 24 1945 (Date) (By registrar) Hunting Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 3/45 19..., to Apr. 24/45, and that I last saw her alive on Apr. 23/45

Immediate cause of death — Duration

Broncho-Pneumonia — 2 weeks.

Due to —

Due to —

Other Conditions Arterio-Sclerosis — Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Meade Smith, M.D.
Address 933 Hanover St. Apr. 24/45.

VS 150

G28200 G28200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √10

Registered No. Ballon

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 344 Ballon St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Jacqueline Asp.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 13, 1941

8. AGE: Years	Months	Days	If less than one day
4	1	8	— hr. — min.

9. Birthplace Cumberland, Ky. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name William A. Asp.
13. Birthplace North Carolina

MOTHER
14. Maiden Name Hester Poe
15. Birthplace Georgia

16 (a) Informant Father
(b) Address 344 Ballon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 1945 (month) (day) (year)
(c) Cemetery or crematory St. Patrick's
Location Edmondson Ave.

18 (a) Funeral director Rendell & Sproul
(b) Address 32 S. Highland Ave.

19 (a) APR 24 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1945, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1945 to 4/21 1945 and that I last saw her alive on 4/21 1945.

Immediate cause of death Respiratory failure — Duration —

Due to Diphtheria — 11 days

Due to K.L. Bacillus —

Other Conditions Diphtheritic myocarditis — 6 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hospital Date signed 4-21

Huntington Williams, Md

X

G28201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G28201 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Winters Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Noel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1880

8. AGE: Years 65 | Months 7 | Days 4 | If less than one day hr. min.
64

9. Birthplace Catonsville, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses Auston
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Thomas Noel
(b) Address 1927 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 APR 24 1945 (Date received by Registrar) (b) Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945, at 9 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1945 to 4/22 1945, and that I last saw her alive on 4/22 1945

Immediate cause of death: Cirrhosis of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Woodland, M.D.
Address Provident Hospital Date signed 4/25/45

Huntington Williams

X

G28202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122BA

G28202 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5523 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William O. Kendall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marsha J. Kendall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1902

8. AGE: Years	Months	Days	If less than one day
43	10	21	hr. min.

9. Birthplace Rock Hall, Md
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Bethlehem Steel Shipyard

FATHER
12. Name Charles O. Kendall
13. Birthplace Md

MOTHER
14. Maiden Name Florence Dodd
15. Birthplace Md

16 (a) Informant Marjorie C. Kendall
(b) Address 2566 N. Patterson Pk

17 (a) Burial (b) Date thereof 4/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall, Md

18 (a) Funeral director J. H. Whitelock & Son
(b) Address Gilmor & Lombard Sts

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) APR 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1945, at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1945 to 4-22 1945.
and that I last saw him alive on 4/22 1945.

Immediate cause of death	Duration
Intestinal Obstruction & Gangrene	
Due to Volvulus through mesocolon	
Due to Operative procedure for gastroenterostomy	
Other conditions and Ruptured Duodenal Ulcer & Obstruction	

(Include pregnancy within 3 months of death)

Date of operation 4-16-45

Major findings of operation: Peritonitis, Edema of duodenum & Ruptured Ulcer

Of autopsy: Same & Volvulus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W. Stein M. D.
Address St Agnes Hospital Date signed 4/23/45

628203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

628203 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie S. Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race wh | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Ag - Home

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John E. Williams
(b) Address 1005 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Westlawn Cemetery
Location Longwood & Edgewood Ave

18 (a) Funeral director John J. Emrich & Son
(b) Address 1901 Hollins St.

19 (a) (b) Huntington Williams
(Date rec'd by registrar)

APR 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 23 19 45 3204

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to 4-23-1945, and that I last saw her alive on 4/23/1945

Immediate cause of death	Duration
Cerebral Vascular Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. D. Hassaway M. D.

Address Date signed 4/25/45

G28204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B Crehan

Registered No. G28204

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 W. Conn ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 W. Conn st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Crehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50 49			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Patrick Crehan

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Catherine McGraffe

15. Birthplace Baltimore Md.

16 (a) Informant Edward Coghlan

(b) Address Organ Ave Curtis Bay Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Memorial

Location 4300 Frederick Ave

18 (a) Funeral director John Lawrence Hoen

(b) Address 901 Hollins St

19 (a) APR 24 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH April 23 1945 at 12 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed April 25 1945

VS 151

X

G28205

TN. 90735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28205

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. None
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Kaercher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct . 1st 1908

8. AGE: Years 36 | Months 6 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kaercher (D
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Kaercher
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Signature of registrar) (b) Registrar

APR 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1945 19 , at 9.20 A.M M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18-44 19 to 4-21-45 19 , and that I last saw h er alive on Apr. 21 19 45 .

Immediate cause of death	Duration
Pulmonary tuberculosis bilateral	2 yrs
Due to	
Due to	
Other Conditions Laryngeal tbc	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.

Address Balto City Hosp. Date signed 4/24/45

628206 Evans #7 628206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
University Hospital 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town B
(If outside city or town limits, write RURAL and give town)
(d) Street No. SHACK B+O R.R. WEST SIDE OF GWYNNS FALLS
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Bowers ?

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY APR 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 45 19 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock.

Due to Second + third degree burns involving 90% of body

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/3

(a) Date of injury 12:35 P.M. 3-10-45
(b) Where did injury occur? VICINITY OF B+O R.R. W OF GWYNNS FALLS
(c) Did injury occur at home, on farm, industrial place, in public place? SHACK - WOODS While at work? No.
(d) Means of injury FOUND BURNED.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed March 12, 1945.

G28:07 Reserve #6 G28:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr - ? Unknown Black Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65? Months Days If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory PUBLIC CEMETERY APR 23 1945
Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 APR 24 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 19 45 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 30 19 45 to Mar 31 19 45 and that I last saw him alive on Mar 31 19 45.

Immediate cause of death	Duration
Cardiac failure	
Due to Pneumonia, Lobar, Bilateral	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Arnow

Address Johns Hopkins Date signed 4-24-45

G28208 G28208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1831 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Margaret F. Weaver

3 (b) If veteran, name war ..... | 3 (c) Social Security Account No. .....

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 2 - 1921

8. AGE: Years 23 | Months 11 | Days 2/20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name John M. Weaver
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Rosa E. Flores
15. Birthplace Jacobsville Md.

16 (a) Informant John M. Weaver (Father)
(b) Address 1831 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Hyppe & Hyppe
(b) Address 1476 Light St.

19 (a) APR 24 1945 (b) Registrar .....
Date rec'd by reg.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945 at 10:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
Multiple fractures and
Due to Thrush burns

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 4/22/45 10:P. M
(b) Where did injury occur? Coast Guard Road near Pennington Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Pedestrian struck by auto

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 4/22/45

G28209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706

G28209 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin L. Weaver

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1928

8. AGE: Years	Months	Days	If less than one day
16	4 5	23	hr. min.

9. Birthplace Jacobsville Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John M. Weaver
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Zoia E. Shores
15. Birthplace Talbot Co. Md.

16 (a) Informant John M. Weaver (father)
(b) Address 1931 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) APR 24 1945 Light St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23- 1945, at 1 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock

Due to

Other Conditions Intern Hemorrhage, multiple fractures; Laceration, abrasion & contusion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 4-22-45 at 10 P M.
(b) Where did injury occur? Coast Guard Rd & Pennington Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4/23/45

628210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Register No. 628210

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Allendale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby GIRL Ropach

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1945

8. AGE: Years	Months	Days	If less than one day
			2 hr. 27 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Frederick Ropach
13. Birthplace Monessen, Pa.

MOTHER
14. Maiden Name Eleanor Matilda Shepherd
15. Birthplace Sterrettania, Pa.

16 (a) Informant Mother
(b) Address 2101 Allendale Rd, Zolte, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY APR 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

APR 24 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 1:49 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945 to April 18, 1945 and that I last saw her alive on April 18 1945

Immediate cause of death Asphyxia Neonatorum — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel C. Bonfield, M.D.
Address Woman's Hosp. Date signed 4/30/45

X

G28211 G28211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 E. 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1707 E. 25th St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Kennedy

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bernard Kennedy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1891

8. AGE: Years	Months	Days	If less than one day
53	6	10	..... hr. ..... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Duffy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Carthy
15. Birthplace Ireland

16 (a) Informant Mr. Bernard Kennedy
(b) Address 1707 E. 25th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Eppner & Son Inc.
(b) Address 118 N. Mt. Royal Ave

19 (a) (Date received by Registrar) APR 24 1945 (b) Huntington Nibbeviller, Registrar, M.D.

US 164

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23- 1945, at 10 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 4-23-45

G28212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G28212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 N. Milton Ave
(c) Hospital or institution: 8 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-1006

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 19th 1885

8. AGE: Years	Months	Days	If less than one day
60	3	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edwin Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Caldwell
15. Birthplace Md.

16 (a) Informant Amelia von Kenaen
(b) Address 1702 N. Milton Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Registrar's signature) APR 24 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15- 1945 to 4-23- 1945 and that I last saw her alive on 4-21- 1945

Immediate cause of death	Duration
Generalised Carcinomatosis	2
Due to Carcinoma of left breast	1940
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Laug M. D.
Address 2117 Belair Rd Date signed 4-24-45

VS 150

X

G28213

BALTIMORE CITY HEALTH DEPARTMENT X G28213 Registered No.

CERTIFICATE OF DEATH V 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Just same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #3 Box 300 Dundalk Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WEST

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Edith West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1901

8. AGE: Years 44 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Samuel West
13. Birthplace Penna.

MOTHER
14. Maiden Name Emma Taylor
15. Birthplace Penna.

16 (a) Informant Harold West
(b) Address 1304 Eutaw Place Baltimore

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 24-45 (month) (day) (year)
(c) Cemetery or crematory Sweet Orrbley, Pa.
Location Pennsylvania

18 (a) Funeral director Wellman Bock Inc.
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registered

VS 150 APR 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 1945, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1945 to 4/24 1945, and that I last saw him alive on 4/24 1945

Immediate cause of death Cardio-Resp. Failure — Duration

Due to Uremia

Due to Hypertension C-V Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. X. Spalsbury M.D.
Address Mercy Hosp. Date signed 4-24-45

X

M. D. F. 1268-9

G28214

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28214

CERTIFICATE OF DEATH

3 √159

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 N. Fulton St. Ward)

Length of residence in city or town where death occurred.....yrs.....mos.....ds. How long in U. S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME Baby Boulware

(a) Residence: No. 2221 N. Fulton St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (City or town) 227 N. Fulton Ball
(State or country) Baltimore W. Boulware

FATHER

13. NAME

14. BIRTHPLACE (city or town) Ball
(State or country) Md

MOTHER

15. MAIDEN NAME Virginia M. Dawn

16. BIRTHPLACE (city or town) W. Va.
(State or country)

17. INFORMANT Mrs Boulware
(Address) 2221 N Fulton

18. BURIAL, CREMATION, OR REMOVAL

Place PUBLIC CEMETERY Date APR 23 1945, 19...

19. UNDERTAKER Commissioner of Health
(Address)

20. Date APR 24 1945 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 29, 1945

22. I HEREBY CERTIFY, That I attended deceased from March 29, 1945 to March 29, 1945

I last saw baby alive on March 29, 1945 Death is said to have occurred on the date stated above, at 3:00 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Prematurity	
Birth.	
Abt 30 Weeks	

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?.....Date of Injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of Injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
.....If so, specify.....

(Signed) H. C. Taylor M. D.

(Address) 1357 N Fulton Ave 8/29/45

THIS MORGUE MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G28215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1276

G28215

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Mrs. Sadie A. Eaton (Eaton)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Howard E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23. 1895

8. AGE: Years	Months	Days	If less than one day
49	8	29	hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Charles Collins
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Florence Whittington
15. Birthplace A. A. Co. Md.

16 (a) Informant Husband
(b) Address 514 N. Streeper St.

17 (a) Burial (b) Date thereof 4/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

APR 24 1945
(Date rec'd by registrar)

Whittington Williams M.D.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1945 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1945 to 4/25 1945 and that I last saw her alive on 4/21 1945

Immediate cause of death Perforation of the Stomach — Duration

Due to Complication of Plastic Repair Made on Omentum

Due to duct.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/9/45

Major findings of operation: Carcinoma

of autopsy: Perforation of Stomach

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harvey J. Wallace M. D.

Address 1400 N. Caroline St Date signed 4/26/45

G28216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G28216 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 E. Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LLOYD M. GOLDSBOROUGH

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-2062

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M.	W	W

6 (b) Name of husband or wife CLARA KNOPP
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 23 - 1877

8. AGE: Years	Months	Days	If less than one day
68	2	-	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation WATCHMAN
11. Industry or business

FATHER
12. Name Wm
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Not known
15. Birthplace Baltimore Md.

16 (a) Informant Joseph Shaffer
(b) Address 1917 E. Hoffman St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location Row 4 NORTH AVE.

18 (a) Funeral director Clarence F. Hoffman
(b) 1639 N Broadway

APR 24 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1945, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945, to 4/23 1945, and that I last saw h[illegible] alive on 4/22 1945.

Immediate cause of death Carcinoma of Stomach. — Duration 6-12 Mos

Due to

Due to

Other Conditions Arteriosclerotic C.V.R. Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

? PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Shaffer
Address 126 E. Preston St Date signed 4/26/45 M.D.

Huntington Williams, MD

G28217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G28217 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Steelton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel E. Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Gladys G. Mull
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1904

8. AGE: Years	Months	Days	If less than one day
41		4	hr. min.

9. Birthplace Texas
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Bethelhem Fairfield

FATHER
12. Name Mahew Matthews
13. Birthplace Texas

MOTHER
14. Maiden Name Ellen Speck
15. Birthplace Texas

16 (a) Informant Wife
(b) Address 1224 Steelton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory
Location Greenville S.C.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) 4-24-1945 (Date received by Registrar) (b) Wilson Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 3 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Base, Fracture of Pelvis, multiple fractured of ribs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 23 1945 10 A.M.
(b) Where did injury occur? Bethlehem Shipyards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Crushed by heavy weight

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 24 1945

X

G28218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G28218 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Arlington Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Barbara Ann (Torian) Torian

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Col-

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/6/1939

8. AGE: Years 6 | Months 1 | Days 15/16 | If less than one day ..... hr. ..... min.

9. Birthplace Roxboro, N.C. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Eddie Torian
13. Birthplace N.C.

MOTHER
14. Maiden Name Alice Bailey
15. Birthplace N.C.

16 (a) Informant Alice Torian (Mother)
(b) Address 906 N. Arlington, Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Mill Hill Cemetery
Location Roxboro, N.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) APR 24 1945 (date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to (her) death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert La Gratta M.D. Medical Examiner.
Date signed April 23 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

28219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hebrew Home For Aged
(c) Hospital or institution:
Belvedere & Greenspring Ave 21-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Inde Kushnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife. Late Morris S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Joseph Hirsh Grandofsky
13. Birthplace Poland

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Poland

16 (a) Informant Robert L. Kushnick
(b) Address 3439 Reisterstown Road

17 (a) Burial (b) Date thereof April 25, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by registrar) Huntington Williams, MD
APR 25 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3 1943, to 4-23 1945, and that I last saw h alive on 4-23 1945

Immediate cause of death: Hypertension
Ch. end. vas. disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Lurie MD

Address Levindale Date signed 4/26/45

X

628220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

628220 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1906 N. Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Hallem

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3179

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Pepi Hallem
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Litva (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Morris Hallem
13. Birthplace Litva

MOTHER
14. Maiden Name Shifra
15. Birthplace Litva

16 (a) Informant Pepi Hallem
(b) Address 1906 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cemet.
Location 3600 E Balto St

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave

19 APR 25 1945 Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 1945 at 12.15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Kyrle H. McHale M.D. Medical Examiner.
Date signed 4/24/45

628221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467 Registered No. 628221

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31 St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.3 days
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State D. of C. (b) County
(c) City or town Anacostaia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7261 Liverson Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
James Richard Cadell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Agnes McKay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1882

8. AGE: Years	Months	Days	If less than one day
63	1		hr. min.

9. Birthplace Prince George County, Md.
(Town, county, and state)
10. Usual Occupation eng.
11. Industry or business Sea-faring

FATHER
12. Name George William Cadell
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Alice
15. Birthplace Maryland

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, 11, Md.

17 (a) Removal (b) Date thereof 4/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington D C
Location

18 (a) Funeral director Ulman Funeral Home
(b) Address 200 S Calvert St

19 (a) (Signature of registrar) (b) Hunting for Williams M.D.

APR 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1945, to April 24 1945, and that I last saw him alive on April 24 1945.

Immediate cause of death Carcinoma of the head of pancreas. — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: Ca of Head of Pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Shute Clintock M. D.

Address U.S.Marine Hospital Date signed 4/24/45
Baltimore 11, Md.

G28222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28222 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 647 S. Pulaski Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 347 S. Pulaski Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADOLF BIRGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Frieda Birgel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1864

8. AGE: Years	Months	Days	If less than one day
80	6	28 25	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired Car Repairman
11. Industry or business B. & O. R.R.

FATHER
12. Name Karl Birgel
13. Birthplace Russia

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Russia

16 (a) Informant Mrs. Olga A. Clough
(b) Address 347 S. Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4.25.45 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY.

19 (a) APR 25 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH April 22 1945, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945 to 4/22 1945 and that I last saw him alive on 4/22 1945.

Immediate cause of death artero sclerotic cardiac vascular disease — Duration 2 yrs
Due to — Duration
Due to — Duration
Other Conditions Cerebral thrombosis — Duration 1 wk
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 20 30 Wilkens Date signed 4/23/45

VS 150

ave X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28223 ✓ G28223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 N. Fulton Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 81

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Gray.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1863

8. AGE: Years	Months	Days	If less than one day
81.	9	14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Laborer
11. Industry or business —

FATHER
12. Name Richard W. Gray
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Priscilla Hunt
15. Birthplace Anarundel Co. Md.

16 (a) Informant Miss Eliza Gray
(b) Address 1603 N. Fulton Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 25 1945 (Date received by Local Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1945, to Apr 24 1945, and that I last saw h— alive on Apr. 24 1945

Immediate cause of death — Duration

Carcinoma of the Urinary Bladder with Metastases — July 1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Gray M.D.
Address 1663 W Mt. St. Date signed 4/27/45

G28224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G28224

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES HELEN BAER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clothing Designer
11. Industry or business

FATHER
12. Name John Baer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fischer
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Baer
(b) Address 2938 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address APR 25 1945

19 (a) (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1945 to 4-24 1945 and that I last saw h[illegible] alive on 4-24 1945

Immediate cause of death: Conflagration of lungs (Duration: 1 yr.)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward D. Fitzgerald M. D.
Address Maryland General Hospital Date signed 4-25-45

G28225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161Q

Registered No. G28225

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 154 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20-45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leslie Coleman
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Hill
15. Birthplace Amherst Va.

16 (a) Informant Sarah Hill
(b) Address 704 W. Lafayette Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 24 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 25 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22- 1945, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1945 to 4-22 1945, and that I last saw him alive on 4-22- 1945

Immediate cause of death: Atelectasis — Duration: 2 d 7

Due to: I

Due to:

Other Conditions: Prolonged labor — 2 d 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Louise Young M.D.
Address 1100 Dover Street Date signed 4/24/45

2665

G28226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G28226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. For correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A A Co.
(c) City or town Ft. George Meade
(If outside city or town limits, write RURAL and give town)
(d) Street No. A & T. Rd #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bell.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Baby

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-45

8. AGE: Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George F Bell
13. Birthplace —

MOTHER
14. Maiden Name Hanna Bell
15. Birthplace —

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 23 1945
18 (a) Funeral director Commissioner of Health
(b) Address
19 APR 25 1945 (Huntington Williams M.D.) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 3:58 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1945 to 4-16 1945 and that I last saw h[illegible] alive on 4-16 1945.

Immediate cause of death	Duration
Respiratory failure	
Prematurity	3 hr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nicholas A. Nazzar M. D.
Address Johns Hopkins Hosp. Date signed 4-21-45

VS 150

2666

G28227

472438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

G28227 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Worsham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-31-45

8. AGE: Years	Months	Days	If less than one day
	2	7018	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Percy Worsham
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Burton
15. Birthplace Md

16 (a) Informant Reconda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Locat JOHN HOPKINS MEDICAL SCHOOL APR 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (APR 25 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

2667

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1945, to April 18 1945, and that I last saw h.r alive on April 18 1945

Immediate cause of death	Duration
Circulatory failure	1 day
Due to Cardiac failure	
Marasmus	
Due to Agyodermia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. Nyzar M. D.
Address Johns Hopkins Hosp Date signed 4-22-45

X

8228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G28228

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Gilmor
(c) Hospital or institution: Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town HARWOOD Harwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Hopkins #A"

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/45

8. AGE: Years | Months | Days 7 6 | If less than one day ....hr. ....min.

9. Birthplace Harwood, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hopkins
13. Birthplace

MOTHER
14. Maiden Name Malinda Sharp
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 25 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 4/20 1945 and that I last saw h-- alive on 4/20 1945

Immediate cause of death	Duration
Atelectasis, ? lung	
Due to Intraparietal hemorrhage	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert D. Mabry M. D.
Address Univ. Hosp. Date signed 4/20

VS 150

2668

X

G28229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G28229

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene
(c) Hospital or institution: Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town HARWOOD Harwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby girl Hopkins #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If [illegible] give date years

7. Birth date of deceased (mo., day, yr.) 4/14/45

8. AGE: Years | Months | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Harwood Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name John Hopkins
13. Birthplace

MOTHER
14. Maiden Name Malinda Sharp
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (Date rec'd by registrar)

UNIVERSITY MEDICAL SCHOOL APR 23 1945
Commissioner of Health
APR 25 1945
Hunter H. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945, to 4/16 1945, and that I last saw h[illegible] alive on 4/16 1945

Immediate cause of death	Duration
Atelectasis	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Franks M. D.

Address [illegible] Date signed 4/24/45

VS 150

2669 Hosp. X

G28230
30 #93156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42D

G28230
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Daniels

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Dora (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? -91 18?

8. AGE: Years 55 | Months ? | Days ? | If less than one day hr. min.
54

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Lawrence (d)
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lucy ?
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wellington A Jackson
(b) Address 916 Pennsylvania ave

19 (a) APR 25 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945, 2:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16, 1945, to Apr. 22, 1945, and that I last saw h.im alive on Apr. 22, 1945.

Immediate cause of death Cyanosis
Interval between onset and death
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration
7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Balt. City Hosp. Date signed 4-25-45

G28231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G28231 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The physicians; please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3927 Fresby Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 Fresby
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J Gough

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anne H Gough
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 23 1864

8. AGE: Years 80 | Months 6 | Days 30 29 | If less than one day hr. min.

9. Birthplace Centreville Md
(Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business Retired

12. Name John R Gough
13. Residence Centreville Md

14. Maiden Name Hester a Mortgage
15. Birthplace Maryland

16 (a) Informant Mark P. Shirley (nephew)
(b) Address 3927 Fresby

17 (a) Burial (b) Date thereof April 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E Wards Co

18 (a) Funeral director John E Moran
(b) Address 3600 E Baltimore St

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 25 1946

V3 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to April 22 1945 and that I last saw h alive on April 21 1945

Immediate cause of death
(a) Bronchial Pneumonia — Duration 3d.
Due to (b) Common Bronchitis — 1 yr
Due to (c)
Due to (d)

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E E a Stevens M.D.
Address 279 Hanford Av Date signed 4 24 45

G28232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G28232 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 S Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 S PACA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. ROLES

3 (b) If veteran, name war —

3 (c) Social Security Account No. 342-18-4364

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife MARY J. ROLES 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 6-1866

8. AGE: Years 78 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation CARPENTER.

11. Industry or business —

FATHER
12. Name WILLIAM ROLES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY A. WARFIELD
15. Birthplace MARYLAND

16 (a) Informant MRS VIOLA. MOOG
(b) Address 1007 S. PACA ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL-27-45 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL CEM. A. A. Co.
Location

18 (a) Funeral director Bernard E. Healy
(b) Address 121 E WEST ST

19 (a) (Date rec'd by registrar) APR 25 1945 (b) Williamsport

vs 110

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 24 1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1940 to 4-24 1945 and that I last saw h[illegible] alive on 4-24 1945

Immediate cause of death: Acute Cardiac Failure — Duration 10 h

Due to: Cardiovascular Renal Disease — 5 yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

25. Signature Joseph F Lancaster M. D.
Address 479 Washington Blvd Date signed 4/24/45

G28233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G28233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. OA
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Connie DeLong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 4- 1944

8. AGE: Years | Months: 11 | Days: 20 | If less than one day: hr. min.

9. Birthplace Paintsville Ky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie deLong
13. Birthplace Vanlear Ky

MOTHER
14. Maiden Name Virgie Adkins
15. Birthplace Vanlear Ky

16 (a) Informant Willie DeLong
(b) Address 1903 Orleans St

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Paintsville
Location Vanlear Ky

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) APR 25 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 9:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Intestinal Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert La Fratta M.D.
Medical Examiner.

Date signed April 24 1945

G28234 G28234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6606 Fairdel Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6606 Fairdel Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Hermani

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife. Christian Hermani
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 th 1882

8. AGE: Years	Months	Days	If less than one day
63 62	3	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Ernest Lorch
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Miller
15. Birthplace Germany

16 (a) Informant Christian Hermani
(b) Address 6606 Fairdel ave

17 (a) Cremation (b) Date thereof April 26th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Lehrer Funeral Home
(b) Address 2008 E Orleans St

19 (a) APR 25 1945 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I last attended deceased from April 14 1945 to April 23 1945, and that I last saw h[illegible] alive on April 22 1945.

Immediate cause of death	Duration
Chronic Pyelonephritis	5 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 4/24/45

VS 150

G28235 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G28235

CERTIFICATE OF DEATH 83a

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 E 31st St., St., Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Jessie M. Smyth

If U. S. Veteran specify WAR

(a) Residence: No. 410 E. 31st St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of De Royce Smith

6. DATE OF BIRTH (month, day, year) Oct 10, 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	6	8 14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Frederick Kell

14. BIRTHPLACE (city or town) (State or country) Richmond Va.

MOTHER

15. MAIDEN NAME Emma Louise Pitts

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Mr. De Royce Smith

(Address) 410 E. 31st St.

18. BURIAL, CREMATION, OR REMOVAL

Place Greenmount Date 4-26, 1945

19. UNDERTAKER Loring Byers.

(Address) 5005 Park Heights Ave

20. F[illegible] APR 25 1945 Huntington Williams Registrar

VS 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4/24/45

22. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1943 to 4/24/45

I last saw her alive on about 3/1/45 Death is said to have occurred on the date stated above, at 12 pm.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy, cerebral	

Other contributory causes of importance:

Cerebral arteriosclerosis	

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

NO If so, specify

(Signed) Wm B Searle, M. D.

(Address) 311 MEDICAL ARTS BLDG.

X

G28236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G28236 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31 St.
(c) Hospital or institution: Baltimore 11, Md. U.S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Colonial Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Dewey Pruitt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1903

8. AGE: Years	Months	Days	If less than one day
42	2	19	hr. min.

9. Birthplace Tangier, Va. (Town, county, and state)
10. Usual Occupation Master
11. Industry or business Sea-faring

FATHER
12. Name Wm. S. Pruitt
13. Birthplace Tangier, Va.

MOTHER
14. Maiden Name Polly A.
15. Birthplace Tangier, Va.

16 (a) Informant Records, U.S. Marine Hosp.
(b) Address , Baltimore , 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-45 (month) (day) (year)
(c) Cemetery or crematory Longuey
Location Longuey, Va.

18 (a) Funeral director Wilson & Son Inc
(b) Address 1219 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 APR 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 3:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945, to April 24 1945, and that I last saw him alive on April 24 1945.

Immediate cause of death	Duration
Rheumatic Heart Disease with auricular fibrillation and congestive heart failure	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. F. Jones M. D.
Address Baltimore Md Date signed 4/24/45
U.S. Marine Hospital

G28237
JO #98418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G28237

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 N. Washington St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME: Bertha Sachs
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-01-9382

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife John
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	28	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Nathan Abrams (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Strauss (d)
15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 26-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Grant H. Seitz
(b) Address 814 N 36th St Huntington Williamsport, Md.

19 (a) Registered APR 25 1945 (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945 19 ..., at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5, 1945 to Apr. 22, 1945 and that I last saw her alive on Apr. 22, 1945.

Immediate cause of death	Duration
Hypostatic pneumonia	3 days
Uremia	3 days
Due to Carcinoma of breast with metastasis to	?
Due to lungs & liver	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: Carcinoma of breast with metastasis to lungs & liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Hauck E. Bolton
Address Balt. City Hosp. Date signed M/D 4/23/45

X

G28238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G28238

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave
(c) Hospital or institution: Woods Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary McCaffery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, ~~married~~, widowed, or divorced: Widow

6 (b) Name of husband or ~~wife~~: Patrick E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1869

8. AGE: Years 75 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name William Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Gerard Feldman
(b) Address 1951 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Old Frederick Road

18 (a) Funeral director John A. McCann
(b) Address 3000 E. Baltimore St

19 (a) APR 25 1945 (b) Registrar
Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945 at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1945 to Apr 23 1945 and that I last saw h[illegible] alive on Apr 22 1945

Immediate cause of death	Duration
Chronic Myocarditis	2 yrs
Due to Arteriosclerosis	1 yr
Cardiac Decompensation	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irene Mowery
Address Lacona Ave Date signed 4/25

James G. Howette

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

G28239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (years) (days) 25 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2058 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Mr. Anthony J. Barranco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife: Lillian Barranco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/29/95

8. AGE: Years	Months	Days	If less than one day
49	9	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Barber's own business

FATHER
12. Name Joseph Barranco
13. Birthplace Italy

MOTHER
14. Maiden Name Maria De Luca
15. Birthplace Italy

16 (a) Informant Lillian Barranco
(b) Address 2058 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location N. Ave. Apex

18 (a) Funeral director Philip E. Malley Son
(b) Address 243 E. Oliver St.

19 (a) (Date filed) (b) Registrar Witness

APR 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1945, at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30/45 19 to 4/24/45 19, and that I last saw him alive on 4/24/45 19.

Immediate cause of death: Acute congestive Heart Failure — Duration

Due to: Pneumonectomy

Due to: Carinoma of Rt. Lung.

Other Conditions: Hepatomegaly, Acute

(Include pregnancy within three months of death)

Date of operation 4/17/45

Major findings of operation: Ca of rt. lung

of autopsy: Ac. Congest. Ht. Failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmond Scanne
Address St. Josephs Hospital Date signed 4/25/45

G28240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169 over

G28240 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 S. Hanover St
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? o (Yes or No)
If yes, name country

3 (a) FULL NAME Earl (E) D. Bess

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 17-1902

8. AGE: Years	Months	Days	If less than one day
43	—	7	hr. min.

9. Birthplace Huntington - West Va.
(Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Penna - R.R.

FATHER
12. Name Edward Meyers
13. Birthplace Ohio

MOTHER
14. Maiden Name Demma - Bess
15. Birthplace Huntington - W. Va.

16 (a) Informant E. M. D. Steele
(b) Address Huntington - W. Va.

17 (a) Burial (b) Date thereof April 26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Huntington W. Va.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2405 - E. Oliver St.

19 (a) (b)
(Date rec'd by registrar) APR 25 1945 Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 24 1945 at 10 A.M.
(b) Where did injury occur? R.R. yards near City Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Run over by freight car

23. Signature Robert L. Fratzer M.D.
Medical Examiner.
Date signed April 24 1945

G28241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G28241

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 823 S. Rose St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 823 S. Rose St (If outside city or town limits, write RURAL and give town)

(d) Street No. Balto. Md. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Jankowicz

3 (b) If veteran, name war WW

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife F/sic

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1898

8. AGE: Years 46 | Months 7 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation helper on Truck

11. Industry or business City

FATHER 12. Name Frank Jankowicz

FATHER 13. Birthplace Poland

MOTHER 14. Maiden Name Antonina ?

MOTHER 15. Birthplace Poland

16 (a) Informant Estella Jankowicz

(b) Address 823 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Dundalk Rd

18 (a) Funeral director Stephen J. Fialkowski

(b) Address 1100 S. Kenwood Ave.

19 (a) (Date rec'd by local reg.) (b) Apr 25 1945 Huntington Williams, M.D.

vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945 to April 21 1945 and that I last saw h... alive on April 21 1945

Immediate cause of death Coronary Thrombosis

Due to Heart Disease

Due to Coronary Occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc., place) While at work?

(e) Means of injury

23. Signature Frank Jankowicz M.D.

Address 1000 Eastern Ave Date signed 4/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

28242

BALTIMORE CITY HEALTH DEPARTMENT

TN. 93046 **CERTIFICATE OF DEATH** 1860 Registered No. G28242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Patapsco Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Younger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30th 1874

8. AGE: Years	Months	Days	If less than one day
70	4	3 23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Younger
13. Birthplace Germany

MOTHER
14. Maiden Name Carrie Werest
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director F.A. Krause & Son
(b) Address 1946 S. Charles St.

19 APR 26 1945 (Date rec'd by registrar) (b) Huntington Willi... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23rd 1945 19 , at 6.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 19 45 to Apr. 23 19 45 and that I last saw him alive on Apr. 23rd 19 45.

Immediate cause of death: Uremia / Cardiac Failure — Duration: 5 days 3 hrs

Due to

Due to

Other Conditions: Fracture Neck of Femur (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Myocardial failure, pulmonary

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4-10 45 at 7 M
(c) Where did injury occur? near his home (City or town) Baltimore (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? On Street (Specify type of place) While at work? No
(e) Means of injury Fell on street

23. Signature E J Perry M.D.
Address Baltimore City Hospitals Date signed 4-26-45 M. D.

G28243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 151a

Registered No. G28243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 Marshall st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Marshall st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Thomas

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: xxx

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband William Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10th 1880

8. AGE: Years	Months	Days	If less than one day
64	4	14	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Walter Kirkwood
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Agnes (Unknown)
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Jackson
(b) Address 1520 William st

17 (a) Burial (b) Date thereof 4/27/45
(Burial, ~~cremation, or removal~~) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location a.a Co. Md

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul st.

19 APR 26 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 13 1944, to 4/24 1945, and that I last saw her alive on Apr. 24 1945

Immediate cause of death	Duration
Hypertensive cardio vascular renal disease	1 year
Due to —	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Weisel
Address 1226 Hanover St. Date signed 4/25/1945

X

G28244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 3 / B

Registered No. G28244

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution: Aged Men & Women's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ida Phoebe Love

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Nov 11th 1858
8. AGE: Years 86 Months 5 Days 23 If less than one day hr. min. 3
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name John A. Love
13. Birthplace

MOTHER
14. Maiden Name Amy Love
15. Birthplace

16 (a) Informant Records Aged Women's & Aged Men's Home
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook & Sue
(b) Address 1217 St. Paul St.

APR 26 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24th 1945, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20/1941, to 4/24/1945, and that I last saw her alive on 4/23/45 19

Immediate cause of death Uraemia — Duration 2 wks.

Due to Chronic nephritis about — 10 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Judd. M.D.
Address 11 E. Chase St., City Date signed 4/25/45

G28245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28245 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 W 36th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Magdeline Frances Alexander

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: Edward T. Alexander
6 (c) If alive, give age: Berry Point Hosp 78 years

7. Birth date of deceased (mo., day, yr.) July 25th 1869

8. AGE: Years	Months	Days	If less than one day
75	8	29	..... hr. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: at Home

FATHER
12. Name: Henry Schnitker
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Kruse
15. Birthplace: Germany

16 (a) In: Rec'd Union Memorial Hospital
+ Harry A. Wagner 1900 N. Washington St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery Emmanuel
Location Gordon Lane Balto Md
18 (a) Funeral director: William Cook Inc
(b) Address: 1417 St. Paul St
19 APR 26 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945 at 6:26 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945 to April 24 1945, and that I last saw h[illegible] alive on April 24 1945

Immediate cause of death	Duration
Cardio - Respiratory Failure	
Due to Arteriosclerotic Heart Decompensation	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Glenn P. Grove
Address Union Memorial Hosp. Date signed 4/24/45 M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

628246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

628246 ✓ 930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Bauldin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Dorothy A. (nee Schaefer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1891

8. AGE: Years	Months	Days	If less than one day
55 yrs.	11	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Penna. R. R.

FATHER
12. Name Thomas Edwards
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ella Lang
15. Birthplace Baltimore, Md.

16 (a) Informant wife
(b) Address 607 N. Bouldin Street

17 (a) Burial (b) Date thereof 4/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 APR 26 1945 (b) Huntington Mills, Md.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 1945, at 11 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1945 to 4-24 1945 and that I last saw h-- alive on 4-24 1945

Immediate cause of death Cardiac Failure — Duration

Due to Chronic Rheumatic C.V.D.

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Joseph Hosp Date signed 4-24-45

G28247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 10

G28247 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Cliftmont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Cliftmont Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SIMA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Emil Sima

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1862

8. AGE: Years 82 yrs. | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Vaclav Puzicka
13. Birthplace Czech.

MOTHER
14. Maiden Name Caroline Zelenka
15. Birthplace Czech.

16 (a) Informant Mrs. Edw. Neuman (daughter)
(b) Address 3405 Cliftmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Phila. Rd. Balto. Md.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) APR 28 1945 (Date received by Registrar) (b) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1938 to 4/23 1945 and that I last saw h[illegible] alive on 4/21 1945

Immediate cause of death: Uremia Chronic Cardiovascular Renal disease — Duration: 6 yrs 10 yrs

Due to

Due to

Other Conditions Hypertension — 6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen L. Sikorsky M. D.

Address 5939 N. Charles Date signed 4/24/45

G28248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G28248 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1904

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~DEMAGGIO CARMELLO~~ Carmelo DiMaggio

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-0569

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Clementine(nee Ferrari

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1865

8. AGE: Years	Months	Days	If less than one day
80 yrs.	2	9	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Gaetano DiMaggio
13. Birthplace Italy

MOTHER
14. Maiden Name Vincenta Cgnibene
15. Birthplace Italy

16 (a) Informant J.J.DiMaggio - son
(b) Address 1316 N. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Belto. Md.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by Registrar) (b)

APR 26 1945 Huntington Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 1945, at 11 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1945 to 4/24 1945.
and that I last saw him alive on 4/24 1945.

Immediate cause of death Coronary Infarction

Duration

Due to

Due to

Other Conditions Carcinoma of Recto-Sigmoid
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman, M. D.
Address Sinai Hospital Date signed 4/24/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

628249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Daytona ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Feit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/45

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adolph Feit
13. Birthplace Austria

MOTHER
14. Maiden Name Jean Venger
15. Birthplace N.Y.

16 (a) Informant Adolph Feit
(b) Address 4406 Daytonia ave

17 (a) Burial (b) Date thereof 4/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cem
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 W. North ave

19 (a) (b) Huntington Maryland
(Date received by registrar)

APR 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1945 to April 1945 and that I last saw him alive on Apr. 24 1945

Immediate cause of death Respiratory failure — Duration

Due to Prematurity — 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen L Howe M. D.
Address University Hosp. Date signed 4/26/45

X

G28250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G28250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 TOONE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3445 Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. ARMSTRONG

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: WILLIAM C. ARMSTRONG

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 23 1897

8. AGE: Years 47 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name JOSEPH WILSON
13. Birthplace BALTO.

MOTHER
14. Maiden Name IDA BALDWIN
15. Birthplace BALTO.

16 (a) Informant WILLIAM C. ARMSTRONG (HUS)
(b) Address 3445 Pulaski St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 26/45 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (b) Huntington Williams

(Date received by registrar) APR 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 23 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1945 to Apr. 23 1945 and that I last saw her alive on Apr. 23 1945

Immediate cause of death: Hypertensive C.V. Disease
Cerebral Hemorrhage — Duration: 1-31-45 / 4-23-45

Due to

Due to

Other Conditions None.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Schumunk M. D.

Address 842 S. Exeter Date signed 4-27-45

X

G28251 ✓ G28251

JO #93013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 S. Hawkirk St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Aloysius Gaffney

3 (b) If veteran, name war: W.W.# 1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1890

8. AGE: Years 55 | Months -2- | Days -4- | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation ?
11. Industry or business Maryland Drydock Co.

FATHER
12. Name John (d)
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Judge (d)
15. Birthplace Pennsylvania

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory New National Location Lobby Zeller Jct. Frederick Rd

18 (a) Funeral director [illegible]
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1945, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 9, 1945 to Apr. 24, 1945, and that I last saw h. im alive on Apr. 24, 1945.

	Duration
Immediate cause of death: Pulmonary embolism ?	1 Day
Coronary occlusion ?	1 day ?
Due to: Post operative state	8 days
Due to:	
Other Conditions: fracture R. femur, alcoholism	16 days

(Include pregnancy within 3 months of death)
Date of operation 4-16-45
Major findings of operation: fracture neck right femur
of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/7
(a) Accident, ~~suicide, or homicide~~ Acc.
(b) Date of occurrence April 9, 1945 At 5 M
(c) Where did injury occur? Sidewalk in front of 342 S. Hawkirk (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public (Specify type of place) While at work? no
(e) Means of injury Slipped and fell to ground
23. Signature H. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 4-25-45

APR 26 1945

VS 186 SUBJECT TO APPROVAL OF MEDICAL EXAMINER: Hugh B. McAuley

G28252
JO #93284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G28252
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1914

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Colgate Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME
Bertha Hiley

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1906

8. AGE: Years	Months	Days	If less than one day
36	-4-	-0-	....hr. ....min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Crown Cork & Seal

FATHER
12. Name Joseph Hiley
13. Birthplace ?

MOTHER
14. Maiden Name Anna Reppe
15. Birthplace Pennsylvania

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (b) Date thereof APR. 28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANILAUS
Location DUNDALK AVE.
18 (a) Funeral director Lilly & Zecha
(b) Address 403 S. WOLFE ST.
19 (a) APR 26 1945 Hastings for Williams, Jr.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1945, at 4:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....,
and that I last saw h..... alive on ....19....

Immediate cause of death	Duration
Cerebral hemorrhage	3 hrs
Due to Hypertensive Cardio-vascular Disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 4-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G28253 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 E. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Gemmie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles F. Gemmie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	20 22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John J. Ward
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Dennis
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Lambert
(b) Address 1024 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Apr 24 1945.
and that I last saw h[illegible] alive on Apr 23 19 45

Immediate cause of death Carcinoma breast
Metastases to
Due to stomach [illegible]
Due to Lemonthsag

Duration

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. J. Hurley M. D.
Address 110 E North Ave Date signed 4/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C28254 3 3477 Ab 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91 Q

Registered No. C28254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1817 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Cassley —

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Corinne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-92

8. AGE: Years	Months	Days	If less than one day
53	1	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Cassley

13. Birthplace Maryland

MOTHER 14. Maiden Name Letitia Waters

15. Birthplace Maryland

16 (a) Informant Records

(b) Address

17 (a) Burial (b) Date thereof April 26, 1945 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Balto. Co. Md.

18 (a) Funeral director Mrs. Laws. H. Hartland

(b) Address 1629 West Hill Ave.

19 APR 26 1945 (b) Huntington Williams M.D. (Date received by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 3a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1945, to April 23 1945; and that I last saw him alive on April 23 1945.

Immediate cause of death	Duration
? cerebral embolus	
Ante	
Due to Bacterial infection due	6 weeks
to Pneumococcus Type 12	
Due to involving aortic valve	
Other Conditions Femoral artery thrombosis right leg	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Greene M. D.

Address Johns Hopkins Date signed 4-27-45

G28255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G28255 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 W. Fort Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Granger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61			.....hr. .....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John W. Granger
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet Purdy
15. Birthplace Md.

16 (a) Informant M. Granger
(b) Address 116 W Fort Ave.

17 (a) Burial (b) Date thereof 4-26th 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Frederick Road

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

APR 26 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1945, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Embolism
Cardiovascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 23 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KAROEN FENWICK

G28256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G28256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd
(c) Hospital or institution: Sydenham Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Canton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karoen FENWICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/26/42

8. AGE:	Years	Months	Days	If less than one day
	2	10	29	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Joseph Fenwick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Celia Brackett
15. Birthplace Brunswick Co., Va.

16 (a) Informant Mother
(b) Address 1108 Canton St

17 (a) Burial (b) Date thereof 4/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brad[illegible] Ave Huntington Park

19 (a) (b) Registrar

APR 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 1945, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1945 to 4/24 1945, and that I last saw her alive on 4/24 1945

Immediate cause of death Respiratory failure — Duration

Due to Tuberculosis Meningitis 11 Days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp Date signed 4-24

X

G28257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G28257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 Hollins St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George M. Bentz

3 (b) If veteran, name war —
3 (c) Social Security Account No —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Rose M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 5, 1885

8. AGE: Years 60 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Tobacco Dealer

11. Industry or business Self

FATHER
12. Name Geo. W. F. Bentz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marcella Faye
15. Birthplace Ohio

16 (a) Informant Mrs Rose M. Bentz
(b) Address 1318 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Rt Cary Highway
18 (a) Funeral director John J. Edwards Jr
(b) Address 1101-03 E Hollins St

19 (a) Date received (Registrar's signature) Huntington Williams, M.D. Registrar
APR 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24th 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24-19 45 to 4-24-19 45, and that I last saw h[illegible] alive on 4-24-19 45

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Influenza	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Glass M.D. M. D.
Address 526 Walbrook Jr Date signed 4/26/45

G28258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G28258

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Scott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucille J. Tuglein

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife William F
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 28, 1896

8. AGE: Years	Months	Days	If less than one day
49	1	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name Samuel F. Krauss
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jennie Jones
15. Birthplace Balto Md

16 (a) Informant Mr. William F. Tuglein
(b) Address 523 Scott St

17 (a) Burial (Burial, cremation, or removal), (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2934 Reed Ave

18 (a) Funeral director John L. Conway Son
(b) Address 901-03 Baltimore Nat'l Bank Bldg, Huntington Ave, Md

19 (a) APR 26 1945 (Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24th 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945, to Apr. 24th 1945, and that I last saw h[illegible] alive on Apr 24 1945.

Immediate cause of death Coronary Thrombosis — Duration 24 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry H. Cates
Address 517 Scott St Date signed 4/26/45 (M. D.)

X

G28259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28259 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 39 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3603 Dennlyn Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bessie Schindler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mussa-

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah-

15. Birthplace Russia

16 (a) Informant Miss Anna Schindler

(b) Address 3603 Dennlyn Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location

18 (a) Funeral director Jos. Levin Inc

(b) Address 1439 E. Balto. St

19 (a) APR 26 1945 (b) Huntington Williams M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25/1945 at 3.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1945 to 4/25 1945, and that I last saw her alive on 4/25 1945.

Immediate cause of death	Duration
Coronary occlusion	
Myocardial Infarction, early.	
Due to Myocardial insufficiency	
Due to Coronary sclerosis & arteriosc.	
Other Conditions Diabetes mel. Hemiplegia, right, 2 yrs. Litigation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address 94 Date signed 4/26/45

DR. SHPRITZ

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28260 G28260

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 S. Exeter St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence if city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Hyman [redacted] Lehrman

If U. S. Veteran specify WAR

(a) Residence: No. 30 S. Exeter St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sal

6. DATE OF BIRTH (month, day, year) 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Grocery Store

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Russia

FATHER

13. NAME Sam

14. BIRTHPLACE (city or town) (State or country) Russia

MOTHER

15. MAIDEN NAME Faga

16. BIRTHPLACE (city or town) (State or country) Russia

17. INFORMANT Wife

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Southern Cem. Date 4-27-45

19. UNDERTAKER Jack Levine Inc

(Address) 1439 E. Baltimore St.

20. FILED ..... 19.... Huntingtown, Md.

APR 26 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 26, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan. 2 1943 to April 26 1945

I last saw h[illegible] alive on April 25, 1945. Death is said to have occurred on the date stated above, at 7:15 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Diabetes Mellitus	1940
Arteriosclerosis	1940
Chronic Myocardial Degeneration	1943

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinic Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) A. Sallod M. D.

(Address) 207 E. Fort Ave.

X

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

34877 48261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28261 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County a-a-Co
(c) City or town Brooklyn Pk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10-13 Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Fred Wyble

3 (b) If veteran, name war: M
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Josephine L. Wyble
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-83

8. AGE: Years	Months	Days	If less than one day
61	9	13	hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Master Electrician
11. Industry or business U. S. Coast Guard

FATHER
12. Name William Wyble
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Geiger
15. Birthplace — Germany

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 26 1945 (Date received by Local Registrar) (b) Huntington Mills Barry M.K.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945 at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1945 to Apr. 24 1945; and that I last saw him alive on Apr. 24 1945.

Immediate cause of death: Myocardial failure — Duration
Due to: Diabetes mellitus
Due to:
Other Conditions: Cerebrospinal syphilis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D.B. King M. D.
Address Johns Hopkins Hosp. Date signed 4-24

61

G28262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1 A

G28262 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 W. 20th. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21, 1880

8. AGE: Years 65 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Anna Ruffet
(b) Address 1076 20th. St.

17 (a) Burial (b) Date thereof 3-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Habliston
(b) Address 918 Druid Hill Ave.

19 (a) (b)
Date received by registrar APR 26 1945 Registrar
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/45 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 4/23/45

G28263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94 G28263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) Part
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 682 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Doman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1893

8. AGE: Years 52 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mary Washington
(b) Address 682 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address Druid Hill Ave.

APR 29 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20 1945, at 7:45 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature P. J. Sulcenti M.D.
Medical Examiner.

Date signed 4/30/45

VS 151

G28264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G28264 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3319 Belvedere Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3319 Belvedere Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James M. Trainor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1915

8. AGE: Years	Months	Days	If less than one day
29	4	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John A. Trainor

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary M. Hughes

15. Birthplace Md.

16 (a) Informant John A. Trainor

(b) Address 3319 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Gaber & Sons

(b) Address 1827 W. North Ave.

APR 26 1945 Huntington Williams M.D. (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Childhood 1920, to Apr 24 1945, and that I last saw him alive on Apr 24 1945.

Immediate cause of death	My carditis	10 yrs
Due to	Cardiac Asthma	Life
Due to	—	
Other Conditions	—	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles J. Wells M. D.

Address 5276 Park Heights Ave. Date signed Apr 25 1945

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G28265 Registered No.

1. PLACE OF DEATH: FAIRMOUNT AVE

(a) Baltimore City, Maryland

(b) Street address 834 W Fairmount Av

(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 834 W Fairmount Av (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie McCray Carroll (COPHER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Color

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Carroll Opher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1893

8. AGE: Years 51 Months 8 Days 14 If less than one day hr. min.

9. Birthplace Salisbury Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name James Edward McCray

13. Birthplace Salisbury, Md.

MOTHER

14. Maiden Name Mary Hopkins

15. Birthplace Salisbury Md.

16 (a) Informant Mr. Carroll Opher

(b) Address 834 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) Filed APR 26 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 23 1945, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1945 to 4/23 1945. and that I last saw h[illegible] alive on 4/23/1945.

Immediate cause of death: Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M.D.

Address Date signed 4/26/45

VS 150

G28266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G28266

MARGIN RESERVED FOR BINDING. The information should be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 W. Chesapeake Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua K. Richardson

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bertha Richardson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 4, 1860

8. AGE: Years 83 | Months 5 | Days 22 | If less than one day (hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name Thomas Richardson
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Miles
15. Birthplace Maryland

16 (a) Informant Hospital Chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Clynmalira
Location Monkton, Md

18 (a) Funeral director Landon M. Bunting
(b) Address Sparks, Md.

19 (date received by registrar) APR 26 1945 Huntingtown Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1945, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1945, to 4-26 1945, and that I last saw him alive on 4-26 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Carcinoma of ascending colon	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elsie F. Lane M. D.
Address Union Memorial Hosp. Date signed 4/26/45

VS 150

G28267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 C

G28267 Registered No. (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 5600 Pimlico Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Richard E Cohen.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-45 1944

8. AGE: Years	Months	Days	If less than one day
1		13	hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER / FATHER

12. Name Alfred J. Kotzen Cohen

13. Birthplace Clearfield, Penna

14. Maiden Name Marion G. Kotzen

15. Birthplace New York

16 (a) Informant Alfred J. Kotzen Cohen

(b) Address 5600 Pimlico Road

Burial Cremation (Burial, cremation, or removal) (b) Date thereof 4-27-45 (month) (day) (year)

(c) Cemetery or crematory [redacted]

Location Hebrew Friendship Cem

18 (a) Funeral director A&R Levin Inc

(b) Address 1 APR 26 1945 Balto St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1945, to 4-25 1945, and that I last saw h[illegible] alive on 4-25 1945.

Immediate cause of death Trachea - bronchial obstruction

Due to Edema of trachea - major bronchi.

Due to Acute tracheo-laryngo-bronchitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/25/45

Major findings of operation: Tracheotomy -

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Jenkins

Address Sinai Hosp Date signed 4/26 45 M.D.

G28268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G28268

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner & Dukeland Sts.

(c) Hospital or institution West Balto. Gen Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3316 N. Calvert Stree
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OZETTA PEARL TAYLOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Edward Dillon Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1906

8. AGE: Years	Months	Days	If less than one day
38	11	19	hr. min.

9. Birthplace Charleston, Mo.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name Thomas Richicard Brumfield

13. Birthplace Charleston, Mo.

MOTHER

14. Maiden Name Georgia Ann Waters

15. Birthplace Paduca, Ky.

16 (a) Informant Mr. Edward D. Taylor

(b) Address 3316 N. Calvert Street

17 (a) Burial (b) Date thereof 4/23/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC

(b) Address NORTH AVE. & BROADWAY

19 (a) APR 26 1945 (b) [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 19 45 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 19 45 to 4/24 19 45.

and that I last saw her alive on 4/24 19 45.

Immediate cause of death Uraemia and acidosis — Duration

Due to Kidney Ca with malignant essential Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A. M. Felsenfeld M. D.

Address West Balt. G. H. Date signed 4/25/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48B

G28269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County [illegible]
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary E. Fravel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife Mr. Noah Fravel
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 10 1887

8. AGE: Years	Months	Days	If less than one day
57	9	15 16	hr. min.

9. Birthplace Rohrerstown Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aaron B. Landis
13. Birthplace Lancaster County Pa.

MOTHER
14. Maiden Name Emma Brubaker
15. Birthplace Lancaster County Pa.

16 (a) Informant Mr. N. Fravel
(b) Address Loretto Pa.

17 (a) Removal (b) Date thereof April 26 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Loretto Pa.

18 (a) Funeral director C. N. Fabo Bro
(b) Address Baltimore Md

19 (a) (b)
(Date rec'd by registrar) (Registrar's signature)
APR 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 19 45, to 4/26 19 45, and that I last saw h[illegible] alive on 4/26/45 19 45.

Immediate cause of death Pulmonary embolism — Duration 15 min

Due to

Due to

Other Conditions Carcinoma of uterus — Duration 2 yrs
(Include pregnancy within 3 months of death)

Date of operation 4/22/45

Major findings of operation: Carcinoma of uterus

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grayson D. Wescott M. D.

Address Bon Secours Hosp. Date signed 4/26/45

G28270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G28270 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Curtis Bay Works

(c) Hospital or institution: American Oil Co

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1619 Darley Ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William S. Kirk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude B. Kirk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26 - 1891

8. AGE: Years	Months	Days	If less than one day
53.	5	22.	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Night Guard

11. Industry or business American Oil Co.

FATHER

12. Name John H. Kirk

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Rachel R. Sherman

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Gertrude E. Kirk

(b) Address 1619 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26 1945 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Baltimore Md

18 (a) Funeral director Maurice Cook Syfer

(b) Address 1400 W. North Ave

19 (a) APR 26 1945 (Date filed by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1944, to 4-24 1945, and that I last saw him alive on 4-23 1945.

Immediate cause of death	Duration
Coronary Thrombosis	6 yrs
Due to Myocardial degeneration	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Miller

Address 1400 N Darley Date signed 4/25/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G28271 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Ingleside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Ingleside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertye Shulder

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-1921

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 27, 1897

8. AGE: Years 47 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business May Co Dept Store

FATHER
12. Name Emanuel Buxbaum
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Hannah Rosenberg
15. Birthplace New York

16 (a) Informant Myer Buxbaum
(b) Address 3706 Clarinth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E. Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date registered APR 26 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 9.18

20. DATE OF DEATH April 25, 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to 4/25 1945, and that I last saw her alive on 4/25 1945.

Immediate cause of death: Carcinoma of Stomach — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 1944

Major findings of operation: Carcinoma of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emanuel Buxbaum

Address 2904 Rusk Rd Date signed 4/26/45

G28272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G28272
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Avenue
(c) Hospital or institution:
Pine Grove Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Chesterfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——years

7. Birth date of deceased (mo., day, yr.) May 13, 1900

8. AGE: Years	Months	Days	If less than one day
44	11	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name H. Clinton Carr
13. Birthplace Maryland

MOTHER
14. Maiden Name Hattie May Chaney
15. Birthplace Maryland

16 (a) Informant H. Clinton Carr
(b) Address Chesterfield A. County

17 (a) Burial (b) Date thereof 4/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baldwin Memorial Cemetery
Location Millersville Md.

18 (a) Funeral director B. L. Hopping
(b) Address Annapolis Md.

APR 27 1945 Huntington
(Date received) Registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th, 1945, at 7:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1945, to April 26 1945, and that I last saw him alive on April 25 19 45.

Immediate cause of death: Chronic myocarditis — Duration 15 yrs

Due to Hypertension; Chronic nephritis

Due to

Other Conditions Quadruplegia Atrophic arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. V. Harbold M.D.
M. D.
Address 470.6 Harford Road Date signed 4/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G28273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2214 Cecil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 79

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Francis P. Martini

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months — | Days — | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name Patrick Martini

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Burke

15. Birthplace Ireland

16 (a) Informant Mrs. Martini

(b) Address 2214 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director Mary M. Nudefeld

(b) Address 201 E. 22nd St.

19 APR 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 1945, at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to 4/24 1945, and that I last saw h. alive on 4/ / 1945.

Immediate cause of death Myocardial Insufficiency

Due to Myocarditis

Due to Arteriosclerosis (Secondary)

Other Conditions Cancer of Colon, Intestinal Obstruction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration of Interval
9 mos
9 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Thomas J. Martin

Address 532 E. 22nd St. Date signed 4/26/45 M. D.

VS 150

X

G28274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G28274

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 Hunter St
(c) Hospital or institution: Sewell

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) Entire

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Hunter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Dubosq

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY-9-1876

8. AGE: Years 68 | Months 11 | Days 16 | If less than one day min.

9. Birthplace Philadelphia Pa (City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Philadelphia Penn

MOTHER
14. Maiden Name Unknown
15. Birthplace Germantown

16 (a) Informant Wife
(b) Address 1516 Mosher

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Gatchwood Rd

18 (a) Funeral director Wilson Lodge Inc
(b) Address 2120 Pond

19 APR 27 1945 Filed by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25/45 19 1530 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24/45 to 4/25/45 and that I last saw h[illegible] alive on 4/25/45

Immediate cause of death Bronchopneumonia Duration 24hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Sewell M. D.
Address 50 E Mt Rd Date signed 4/25/45

VS 150

G28275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G28275

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 N. Carey Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary Genevieve Holton McGett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: A. A.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lewis McGett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace St. Mary's Co (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James E. Holton
13. Birthplace St. Mary's Co.

MOTHER
14. Maiden Name Mary Holton
15. Birthplace St. Mary's Co.

16 (a) Informant Clyde Rivers
(b) Address Nephew

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30-1945 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetery
Location North West Balto

18 (a) Funeral director J. a Brooks
(b) Address 1[illegible] N. Carey St

19 APR 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1945, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1945 to 4/25 1945 and that I last saw h[illegible] alive on 10/25 1945

Immediate cause of death: Myocarditis — Duration: 1 da

Due to:

Due to Respiratory Infection (Probably Bronchopneumonia)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson M.D.
Address 1802 Pennsylvania Ave Date signed 4/26/45

G28276 ✓ G28276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Benton Gatch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lillian A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1872

8. AGE: Years 72 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Thomas B. Gatch
13. Birthplace Balto

MOTHER 14. Maiden Name Josephine Foster
15. Birthplace Balto.

16 (a) Informant Lillian A. Gatch
(b) Address 2107 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 27 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Taylor Ave

18 (a) Funeral director W. E. Pumphrey & Sons
(b) Address Howard & Saratoga Sts.

19 (a) APR 27 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945 at 5 A.M. 20

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6, 1944, to April 23 1945, and that I last saw h. alive on April 23, 1945

Immediate cause of death	Duration
Cirrhosis of liver (portal)	Symptoms began in early Summer of 1944
Due to Pneumonia, aleutian pastor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tillen Howard, M.D.
Address 12 E. Eager St. Date signed April 24 45

VS 180

X

G28277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G28277

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2320 Essex Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 24
(If outside city or town limits, write RURAL and give town)
3 2
(d) Street No. 2320 Essex Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lorbiecki

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~wife~~ Emil Lorbiecki

6 (c) If alive, give present address: Deceased

7. Birth date of deceased (mo., day, yr.) Jan-8-1877

8. AGE: Years	Months	Days	If less than one day
68	3	18	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Szulczewski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Pietszak
15. Birthplace Poland

16 (a) Informant Josephine Szczepaniak
(b) Address 1242 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) (Date received by Registrar) (b) Registrar

APR 27 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1945, to Apr. 26 1945, and that I last saw h[illegible] alive on Apr 25 1945.

Immediate cause of death Arteriosclerosis
C.V. Disease
Myocardial Failure — Duration 2-3-45

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Schumacek M. D.

Address 842 S. Eaton Ave Date signed 4-26-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G28278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Currie Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Currie Way (If rural give location)
Currie
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia F. Dolby

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife November 8, 1909

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 35 | Months 5 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard W. Wingate
13. Birthplace Cambridge, Md

MOTHER
14. Maiden Name Hester Holiday
15. Birthplace Cambridge, Md.

16 (a) Informant Paul E. Dill
(b) Address 1413 Currie Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 4914 Belair Road

19 (a) APR 27 1945 (Date received by registrar) Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945 to April 25 1945 and that I last saw her alive on April 15 1945.

Immediate cause of death: Carcinoma of uterus — Duration 8 mos.

Due to —

Due to —

Other Conditions Hemiparesis - Bed sore

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. B. Davis M.D.
Address Dundalk-rr-Md Date signed 4-27-45

G28279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28279 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 George st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 George st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eugene Watson.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-7-1889

8. AGE: Years 55 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, or state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Warner Watson

13. Birthplace ?

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mary T. Timmons

(b) Address 713 George st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 25 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn cem Location Baltimore Md

18 (a) Funeral director Coffman & Jackson

(b) Address 916 Penna ave

19 (a) (Date received by Registrar) APR 27 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 2 a. M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 13 1945 to April 26 1945, and that I last saw him alive on April 26 1945.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration: one yr

Due

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 714 N. Eutaw St Date signed 4-26-45

X

G28280

G28230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully written. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Be sure to give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2155 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Grayson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LELA P. GARDNER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17,1877

8. AGE: Years 68 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Snow Hill, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business --

FATHER
12. Name John H. Riley
13. Birthplace Snow Hill, Md.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Snow Hill, Md.

16 (a) Informant Mr. Chester A. Gardner
(b) Address 2155 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (b) 4 27 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 25, 1945 at 1:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8th 1945 to April 25 1945, and that I last saw h[illegible] alive on April 24 1945.

Immediate cause of death Coronary occlusion — Duration 1 minute

Due to Arteriosclerosis — 3 yrs.

Due to

Other Conditions Carcinoma of uterus (Include pregnancy within 3 months of death) — 2½ yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Park Ave Date signed 4/26/45

VS 150

G28281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G28281

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2821 Montebello Terrace

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2

(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 2821 Montebello Terrace (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Harry D LaBonte Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dorothy M. LaBonte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1877

8. AGE: Years 68 Months 2 Days 26 If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business Penna Railroad Co

FATHER 12. Name Peter LaBonte

13. Birthplace Germany

MOTHER 14. Maiden Name Angna Mueller

15. Birthplace Germany

16 (a) Informant Mrs. Dorothy M. LaBonte

(b) Address 2821 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor Ave. Balto Md

18 (a) Funeral director Gilbert L Hilt Jr

(b) Address 1606 E Chester St

19 (c) APR 27 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1942, to April 25 1945 and that I last saw him alive on April 25 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 minutes

Due to Generalized arterio-sclerosis — years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Henry L. Hermann M. D.

Address 20 E. Preston St. Date signed 4/27/45

VS 150

G28283

AB-95878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G28282 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

15-

14hrs-20min

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1340 N. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Frank Ness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Barbara Ness

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17- 1874

8. AGE: Years	Months	Days	If less than one day
71	1	8	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER

12. Name Harry Ness (D)

13. Birthplace Ohio

MOTHER

14. Maiden Name Mary ? (D)

15. Birthplace Ohio

16 (a) Informant Baltimore City Hospitals(Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetary

Location Taylor Ave Balto 2nd

18 (a) Funeral director Albert L. Hilligs

(b) Address 1006 N. Chester Street

19 (a) (Date rec'd by registrar) (b) Huntington Nitkewicz Registrar

APR 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25- 1945, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24- 1945, to 4-25- 1945, and that I last saw h im alive on 4-25- 1945.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

Duration
?
7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. M. Phillips M.D.

Address Baltimore Md Date signed 4-28-45

G28283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28283 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 George St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H. Jones.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1860

8. AGE: Years 65 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Salisbury, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Helena Jones.
(b) Address 626 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

APR 27 1945 (Date rec'd by local Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23- 1945, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12- 1945, to 4-23- 1945, and that I last saw h[illegible] alive on 4-19- 1945

Immediate cause of death Coronary sclerosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions Myocarditis (chronic)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 4-26-45

VS 150

G28284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G28284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Balto. Hosp. 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1847 Covington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd. G. Sullivan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/43

8. AGE: Years	Months	Days	If less than one day hr.	min.
1	4	7		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Sullivan
13. Birthplace Ired.

MOTHER
14. Maiden Name Flowra Ward
15. Birthplace Ired.

16 (a) Informant Parents
(b) Address 1847 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Jas. L. McCauley
(b) Address 30 E. Lafayette Ave

19 (a) APR 27 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25- 1945 at 7:52 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25- 1945 to 4-25- 1945, and that I last saw him alive on 4-25- 1945

Immediate cause of death Lobar pneumonia
Due to
Due to
Other Conditions Dehydration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
7
1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Schlick M. D.
Address 1213 Light St. Date signed 4-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G28285

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem-Fairfield Dispensary
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. of A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2046 Fountain St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ratajczak RATAJCZAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Rose Ratajczak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1909

8. AGE: Years	Months	Days	If less than one day
35	5	4	hr. min.

9. Birthplace Minn.
(Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business

FATHER 12. Name Michael Ratajczak
13. Birthplace Poland

MOTHER 14. Maiden Name Wally Bentkowska
15. Birthplace Poland

16 (a) Informant Rose Ratajczak
(b) Address 2046 Fountain St

17 (a) Buried (b) Date thereof 4-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Cracknell Son
(b) Address 900 N Chester St
Huntingdon Pennsylvania

19 APR 27 1945
(Date received by Registrar)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 12 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 25 1945 at 12 P M.
(b) Where did injury occur? 28 Bethlehem Shipyards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by falling balance weight

23. Signature Robert E. Gralton M.D.
Medical Examiner.
Date signed April 25 1945

628286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. 628286

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Bonner St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Bonner St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Cluster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~: Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years 44 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Charles
13. Birthplace: Russia

MOTHER 14. Maiden Name: Dade
15. Birthplace: Russia

16 (a) Informant: Harry Lust
(b) Address: 2222 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-45 (month) (day) (year)
(c) Cemetery or crematory: Mishkan
Location: Southern Ave Isreal

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1434 E Baltimore St

19 APR 27 1945 (Date received by registrar) Huntington Hillemann, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 26 1945 M.
(b) Where did injury occur? 3916 Bonner St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Asphyxiation

23. Signature: Howard J. Sneeden M.D.
Medical Examiner.
Date signed 4-27-45

628287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 628287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Mosher Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Cornelius Gilmore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Gladys [illegible]
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 21, 1909

8. AGE: Years	Months	Days	If less than one day
35	11	3	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Cornelius Gilmore
13. Birthplace Lancaster, Co Va

MOTHER
14. Maiden Name Lallie Waters
15. Birthplace Baltimore, Md.

16 (a) Informant.....
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director L. Preston Lamberry
(b) Address 519 [illegible]

19 [illegible] (Filed by registrar) (b) ..... Registrar

APR 27 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Myocardial degeneration

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 4/25/45

— over —

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 628288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Butler St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Butler St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Parham

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
C	M	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1891

8. AGE: Years	Months	Days	If less than one day
54	1	21	hr. min.

9. Birthplace Southampton Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Anthony Parham
13. Birthplace Southampton Co. Va

MOTHER
14. Maiden Name Nannah Newsom
15. Birthplace Southampton Co Va

16 (a) Informant Lula Parham
(b) Address 403 Byrne St. Petersburg, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Balto Metl. Cem.
Location Balto. Md.

18 (a) Funeral director Mrs. George N. Hillard
(b) Address 1621 Druid Hill Ave

19 (a) APR 27 1945 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1945, at 9:39 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Degeneration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski Medical Examiner. M.D.
Date signed 4/24/45

G28289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. G28289

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Julia Davis
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) DEC. 17, 1878

8. AGE: Years	Months	Days	If less than one day
66.	4	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Insurance agent
11. Industry or business Home Fire Insurance Co.

FATHER
12. Name Joseph Davis
13. Birthplace Westmoreland Co, Va

MOTHER
14. Maiden Name Amelia Orlan
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Julia Davis
(b) Address 2903 Montebello Ter.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudand Memorial Park
Location Parkville

18 (a) Funeral director Frederick H. Dole
(b) Address 700 W Lombard St

19 APR 27 1945 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1945, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest on and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 4/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28290
AB-93236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

930 Registered No. G28290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Bloom St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- ? 1882

8. AGE: Years	Months	Days	If less than one day
62	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Roberts (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Jackson (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Leg. G. Gleason
(b) Address 1303 Presstman

19 (a) APR 27 1945 (b) Huntington Williams
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25- 1945, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1945 to 4-25 1945, and that I last saw h.er alive on 4-25- 1945.

Immediate cause of death Cardiac failure

Duration

Due to Hypertension and Cardiovascular disease ?

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Aut.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Rudolph M. D.
Address Baltimore Md Date signed 4-27-45

628291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 628291

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Mulberry Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eugene Harris

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife.....
6 (c) If alive, give age.....years
7. Birth date of deceased (mo., day, yr.) Sept 8, 1900
8. AGE: Years 44 Months 7 Days 18 If less than one day ...hr. ...min.
9. Birthplace Alford South Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ben Harris
13. Birthplace Alford South Carolina

MOTHER
14. Maiden Name Elizabeth Rogers
15. Birthplace Alford South Carolina

16 (a) Informant John Harris
(b) Address 1606 N Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1945 (month) (day) (year)
(c) Cemetery or crematory National Baltimore
Location Baltimore City

18 (a) Funeral director Joseph A Bucky
(b) Address 1400 West Pratt St Baltimore 23, Md.

19 (Date received by registrar) APR 27 1945 Hunting for Notification, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1945, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1945 to 4-26 1945, and that I last saw h.. alive on 4-25 1945.

Immediate cause of death 1) Cyanosis — Duration
2) General debility
Due to carcinoma of L. Lung with Generalized metastasis
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature M. M. Gilchrist
Address University Hosp. Date signed 4/26/45 M.D.

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G28292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Homestead Street
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1713 Homestead Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES CONRAD BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife vatherine Brown
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1887

8. AGE: Years	Months	Days	If less than one day
78	2	23 20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk, ret. 8 yrs
11. Industry or business City of Baltimore

FATHER
12. Name Louis Brown
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Fleugle
15. Birthplace Germany

16 (a) Informant Mrs. vatherine Brown
(b) Address 1713 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore Street

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 27 1945 (To be filled in by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 7.05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 20 1945, to APRIL 24 1945, and that I last saw him alive on APRIL 24 1945.

Immediate cause of death	Duration
A.R. ARTERIOSCLEROSIS	4 YRS
HYPERTENSION	10 YRS
Due to	
Due to	
Other Conditions UREMIA	4 WKS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J Cavanaugh M D M. D.
Address 3215 McElderry St Date signed 4-25-45

VS 150

G28293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

Registered No. G28293

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 629 W. Baltimore St.

(c) Hospital or institution:

4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

W

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 629 W. Baltimore (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Alice W. Cherry

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Shelton D. Cherry

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1885

8. AGE: Years 60 | Months 2 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Clarksburg W. Va. (Town, county, and state)

10. Usual Occupation House Keeper.

11. Industry or business Hotel Armistead

FATHER

12. Name William J. Walden

13. Birthplace W. Va.

MOTHER

14. Maiden Name Martha R. ?

15. Birthplace W. Va.

16 (a) Informant Shelton D. Cherry

(b) Address 629 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 28. 1945 (month) (day) (year)

(c) Cemetery or crematory London Park

Location City

18 (a) Funeral director Mrs. John W. Teufel's Son

(b) Address 801 W. Fayette St. Baltimore

19 (a) APR 27 1945 (Date received by Registrar) (b) Huntington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 26 1945, and that I last saw him alive on April 26 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: Apr 2 1945

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Elliott Seagrotta M. D.

Address 1729 W Lombard St. Date signed 4/27/45

VS 180

X

G28294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-20

Registered No. G28294

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Mont Royal (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lydall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-06-78

8. AGE: Years 66 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Electrical Engineer

11. Industry or business

FATHER 12. Name John H. Lydall

13. Birthplace England

MOTHER 14. Maiden Name Mary French

15. Birthplace England

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 4/27/45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md.

18 (a) Funeral director Wm. J. Tichnor & Sons

(b) Address [illegible] Md.

19 (a) APR 27 1945 (b) Huntington Williamsport

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945, to April 25 1945, and that I last saw h[illegible] alive on April 25 1945

Immediate cause of death Heart failure due to complete obstruction of inferior vena cava

Due to Neoplasm of right kidney extending directly into right renal vein

Due to

Other Conditions Oedema of lower extremities + ascites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ross L. McLean M. D.

Address Johns Hopkins Hospital Date signed 4-27-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28295 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Mura St
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Mura St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Benjamin Lucias Blackstock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Olive E Blackstock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Ded 13 1892

8. AGE: Years 52 | Months 4 | Days 8 12 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Craneman Steel Work

11. Industry or business

FATHER
12. Name William A Blackstock
13. Birthplace Va

MOTHER
14. Maiden Name Olivia Darden
15. Birthplace Va

16 (a) Informant Mrs Olive Blackstock
(b) Address 706 Mura St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof April 28/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

APR 27 1945 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25/45 19 9 am at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1945 to 4/25 19 and that I last saw h[illegible] alive on 4/24 19

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerosis — Duration: 2 y.

Due to: — Duration:

Other conditions: Cerebral Hemorrhage — Duration: 24 h.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blume M.D.

Address 1206 E. Preston Date signed 4/26/45

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

AB-90884 G28296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos- 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 S.Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Klingmeyer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3- 1882

8. AGE: Years	Months	Days	If less than one day
62	5	22	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Klingmeyer
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Volk
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Meadow Ridge (b) Date thereof April 28th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Boule

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Gilmore

19 (a) 4-27-1945 (b) Washington Wilson Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25- 19 45, at 5.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14- 19 44 to 4-25- 19 45 and that I last saw h im alive on 4-25- 19 45

Immediate cause of death Bronchopneumonia — Duration 6 days.

Due to Hypostatic pneumonia

Due to Left hemiplegia

Other Conditions Hypertensive Cardio-Vascular Renal. — Duration 1 yr. 4

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.M. Phillips M.D.
Address Balt City Hosp Date signed
J Phillips

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28297 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 N Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N Port St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Frederick Loehr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Loehr
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct 10 1884

8. AGE: Years	Months	Days	If less than one day
60	6	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Cutler
11. Industry or business Tailor

FATHER
12. Name Frederick Loehr
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Ermer
15. Birthplace Germany

16 (a) Informant Katherine Loehr
(b) Address 409 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md
18 (a) Funeral director Welch Funeral Home
(b) Address 2008 Orleans St

APR 27 1945
(Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 26 1945 at 7 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to April 26 1945 and that I last saw him alive on April 26 1945

Immediate cause of death Coronary Occlusion

Duration 4/24/45

Due to

Due to Chronic Myocarditis

1/1945

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bauer M. D.
Address 801 N Kenwood Ave Date signed 4/27/45

X

G28298 2. ✓ G28298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be sure the information is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 Walda Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Walda Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Calvin F. Dennis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1895

8. AGE: Years 49 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name William Dennis
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Millakin
15. Birthplace Md.

16 (a) Informant Eva Hughes
(b) Address 1619 Walda St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Robert A Ellington Sr.
(b) Address 1129 N. Caroline St.

APR 27 1945

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1945, to Apr 29 1945, and that I last saw h[illegible] alive on Apr 29 1945.

Immediate cause of death Coronary Occlusion — Duration Apr 29

Due to Congestive Heart Failure — Duration 1 week

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm A Ellington Jr

Address 1220 N. Bond St Date signed 4/29/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

628299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Pasternak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Antpony Pasternak
13. Birthplace Polatsk

MOTHER
14. Maiden Name Michalina Nasura
15. Birthplace Poland

16 (a) Informant Kostanty Nasura
(b) Address 1121 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 APR 27 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed 4-26-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G28300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 2131 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter S. Hill

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Gladys Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	—	hr. min.

9. Birthplace Cortes Creek, Tennessee (Town, county, and state)
10. Usual Occupation Tavern Keeper
11. Industry or business Self

FATHER
12. Name William Hill
13. Birthplace Tennessee

MOTHER
14. Maiden Name Josephine Carter
15. Birthplace Tennessee

16 (a) Informant: Gladys Hill
(b) Address 2131 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - -45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. County Md.

18 (a) Funeral director Leo h. Schwat
(b) Address 2101 Frederick Avenue

19 APR 27 1945 (b) Huntington Williams, M.D. (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 23 1945, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 1945 to 4-23 1945, and that I last saw him alive on 4-23 1945

Immediate cause of death: Bleeding from esophageal varices — Duration: 2 days
Due to
Due to Cirrhosis of Liver — years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers, M. D.
Address Franklin Sq. Hosp. Date signed 4-24-45

G28301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 919 N. Payson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 919 N. Payson St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Annie Isabelle Atkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband James Carey Atkinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16 1882

8. AGE: Years	Months	Days	If less than one day
63	0	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER

12. Name George Oliver

13. Birthplace Unknown

MOTHER

14. Maiden Name (Unknown) Jones

15. Birthplace Balto. Md.

16 (a) Informant James Carey Atkinson

(b) Address 919 N. Payson St

17 (a) Burial (b) Date thereof 4/30/45 (Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olive

Location Roslyn Md.

18 (a) Funeral director William Cook Inc

(b) Address 1727 St. Paul St.

19 (a) APR 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to April 26 1945 and that I last saw h[illegible] alive on April 25 1945.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to	
Due to	
Other Conditions Old Cerebral Hemorrhage. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Scarpetti M. D.

Address 1729 W Lombard St Date signed 4/27/45

1 CX

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G28302 ✓ 87E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Marys
(c) City or town Pearson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. King
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jewel King
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-16-12
8. AGE: Years 32 | Months 9 | Days 10 | If less than one day ... hr. ... min.
9. Birthplace U.S.
(Town, county, and state)
10. Usual Occupation operating engineer
11. Industry or business

FATHER
12. Name Mark King
13. Birthplace U.S.

MOTHER
14. Maiden Name Amanda Collins
15. Birthplace U.S.

16 (a) Informant Jewel M. King
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30 45 (month) (day) (year)
(c) Cemetery or crematory Oakland Cemetery
Location Galax, Va.
18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1960 Eutaw Place
APR 27 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26- 1945, at 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1945 to 4-26 1945, and that I last saw h[illegible] alive on 4-26 1945.

Immediate cause of death: Pulmonary Embolism Resulting from Hydrocephalus
Due to: Basilar Adhesions
Due to: Meningitis (Chronic)
Other Conditions: Chronic Frontal Sinusitis
(Include pregnancy within 3 months of death)
Date of operation 4/25/45
Major findings of operation: Fronto-Ethmoiditis, Basilar Adhesions
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Loring W. Pratt M.D.
Address Johns Hopkins Hospital 4/27/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28303 Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Belle Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Ward Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. G. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1868

8. AGE: Years	Months	Days	If less than one day
77	3	18	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George F. Ward
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Drummond
15. Birthplace Va.

16 (a) Informant G. Frank Ward
(b) Address 903 W. University Parkway

17 (a) Burial (b) Date thereof 4/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John J. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) APR 27 1945 (b) Received by (registrar) Huntington Willi[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944 to 4/25 1945
and that I last saw h[illegible] alive on 19

Immediate cause of death: Cerebral Hemorrhage & paralysis — Duration: 3 days

Due to: advanced arterio-sclerosis — Duration: 9

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2220 Garrison Blvd. Date signed

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28304 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gay
(c) Hospital or institution: Mercy Dec'd 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4716 Pilgrim Rd. Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mahala V. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edgar A—

6 (c) If dead, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb. 24 - 1884

8. AGE: Years 61 Months 2 Days 2 If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Charles E. Hyde
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Adelaide Balla
15. Birthplace Balto - Md

16 (a) Informant Mr. Edgar A. Johnson
(b) Address 4716 Pilgrim Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 1543 N. Harford Rd.

APR 27 1945 (Date rec'd by registrar)

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1945; at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19__ to 4-26 1945 and that I last saw h[illegible] alive on 4/26 1945

	Duration
Immediate cause of death Pulmonary edema	
Due to Coronary occlusion	
Coronary thrombosis	
Due to Arteriosclerosis	
Other Conditions Obesity	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. D. Lowenstein M.D.
Address Home Date signed 4/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G28305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 S. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V0
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 S. Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam J. Hahn

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-8900

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Anna Glaser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1871

8. AGE: Years	Months	Days	If less than one day
73	9	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Coca-Cola Co

FATHER
12. Name Jacob Hahn
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Grieteheman
15. Birthplace Germany

16 (a) Informant Chas. W. Hahn
(b) Address 4601 Rokeby Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30/45 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Violetville. Balto. Md

18 (a) Funeral director Harry H. Kuitze
(b) Address 401 E. Edmondson Ave

19 (a) APR 27 1945 (Date received by registrar) (b) Registrar Huntington Wilson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 26, 1945, at 5'5. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to April 26 1945, and that I last saw him alive on April 26 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Seagmeth
Address 1724 W Lombard St Date signed 4/27/45 M. D.

628306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 a 628306

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens ave.
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Lin Illicum Hghts.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hammonds Ferry Rd & Nursery
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Lynn (Baby) Semisbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24/45

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Oscar Semisbaugh
13. Birthplace Virginia

MOTHER 14. Maiden Name Ruby Reed
15. Birthplace Virginia

16 (a) Informant Mr. Oscar Semisbaugh.
(b) Address Hammonds Ferry & Nursery Rd.

17 (a) Burial (b) Date thereof 4.27.45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry Hewitzker
(b) Address Md. Dist. Emmorsburg

19 (a) APR 27 1945 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 11.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of Lungs; Subarachnoid Hemorrhage of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20 | 1

(a) Date of injury April 24 1945 3 P M.
(b) Where did injury occur? St Agnes Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Fall following delivery

23. Signature Robert L. Gretter M.D.
Medical Examiner.
Date signed April 25 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G28307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3723 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9514

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife late Johanna Carey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1876

8. AGE: Years	Months	Days	If less than one day
68	7	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Asst.

11. Industry or business Vice Pres. Int. Longshoreman

FATHER
12. Name Patrick Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine —
15. Birthplace

16 (a) Informant Joseph A. Kelly
(b) Address 3723 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd

18 (a) Funeral director Harry A. Wehrley
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1944 to 4/26 1945 and that I last saw him alive on 4/25 1945

Immediate cause of death	Duration
HEART BLOCK, COMPLETE	4/25
Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	4 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3629 Edmondson Ave Date signed 4/27/45 M.D.

VS 150

G28308 Feuchter

BALTIMORE CITY HEALTH DEPARTMENT

G28308 Registered No.

CERTIFICATE OF DEATH 92D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 S Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph P. Feuchter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widow

6 (b) Name of ~~husband or wife~~ Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1862

8. AGE: Years	Months	Days	If less than one day
82	09	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name —
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Howard Feuchter
(b) Address 205 S. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) (b) Registrar

APR 27 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to April 26 1945 and that I last saw him alive on April 26 1945

Immediate cause of death: Cerebral apoplexy — Duration 3 days

Due to: Cerebral Arteriosclerosis — Duration ?

Due to: Chr Endocarditis & Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Feuchter

Address 205 S Castle St Date signed April 26 1945 M.D.

X 1

M. D. B. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

628309 628309

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3049 Frisby Q 14 St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Mildred E. Hillyer

(a) Residence: No. 3049 Frisby St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) May 28, 1899.

7. AGE Years	Months	Days	If LESS than I day, ... hrs. or ..... min.
45	10	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Dry Store

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Albert Lyman

14. BIRTHPLACE (city or town) (State or country) England

MOTHER

15. MAIDEN NAME Elizabeth Lynder

16. BIRTHPLACE (city or town) (State or country) Baltimore Md.

17. INFORMANT Gilbert Hillyer
(Address) 3049 Frisby St

18. BURIAL, CREMATION or REMOVAL
Place Holy [illegible] Ced. Date Apl 30, 1945

19. UNDERTAKER John G Moran
(Address) 3000 E Baltimore St

20. FILED APR 27 1945 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 26, 1945

22. I HEREBY CERTIFY, That I attended deceased from April 13, 1945, to April 26, 1945

I last saw h.. alive on April 26, 1945 Death is said to have occurred on the date stated above, at 11.20 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Squamous cell Epithelioma of Cervical Stump grade III	July 1943

Other contributory causes of importance:

Metastases of Carcinoma to Lungs Apr 13, 45

Metastasis of Carcinoma to Liver

Name of operation Supravaginal Hysterectomy Date of Aug 22, 1938

What test confirmed diagnosis? Biopsy Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
..... If so, specify .....

(Signed) W. Allen Seckert M. D.

(Address) 1127 St Paul St.

G28310 ① BALTIMORE CITY HEALTH DEPARTMENT 937 G28310

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 S.Conkling St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 S.Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Rettman (Rettkowski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nora V.Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.21,1873

8. AGE: Years	Months	Days	If less than one day
71	4	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 812 S.Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) (b) Huntington-Williams M.P.

APR 27 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1945 19 , at 2.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1940 to April 23 1945; and that I last saw h/M alive on April 23 1945.

Immediate cause of death Cerebral Accident — Duration 9 days

Due to A-S-Cardiac Disease — 15 yrs

Due to

Other Conditions Bronchopneumonia — 1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W.W. Davis

Address Dulledaue-nhed Date signed 4/27/45 (M. D.)

X

628311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42D

628311

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 N.Chester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 N.Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A.Cosden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Bessie A.McCoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28,1886

8. AGE: Years	Months	Days	If less than one day
59		28	hr. min.

9. Birthplace Eastern Shore Md.
(Town, county, and state)
10. Usual Occupation Fireman 2nd class
11. Industry or business

FATHER
12. Name James E.
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Mary A.Godfrey
15. Birthplace Eastern Shore Md.

16 (a) Informant Wife
(b) Address 1406 N.Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) APR 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 25 1945; at 6:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 1945 to Apr 25 1945
and that I last saw h[e] alive on 24 1945

Immediate cause of death Cancer of Lung — Duration 1 yr.
Due to
Due to
Other Conditions Metastases to Lymphatic Glands (Neck)
(Include pregnancy within 3 months of death)
Date of operation July 1944
Major findings of operation: Cancer of Lung
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed L. Engelmann M. D.
Address 9858 Hazard R Date signed 4/26/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28312 ✓ G28312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

1. PLACE OF DEATH: Sinai Hospital.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital. 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give location)
(d) Street No. 719 Lake Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Price.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose K. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22/1876

8. AGE: Years 68 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Cutter Laundry

11. Industry or business

MOTHER / FATHER

12. Name Charles Price

13. Birthplace Germany

14. Maiden Name Eva Bachman

15. Birthplace Germany

16 (a) Informant Rose K. Price

(b) Address Cadova Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location City

18 (a) Funeral director Sacred Consolation Chapel

(b) Address 1102 Eutaw St

19 (a) APR 27 1945 (b) (Date received by registrar)

Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1945. at 2:22 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1945 to 4/26 1945 and that I last saw him alive on 4/26 1945.

Immediate cause of death	Duration
Cardio - resp. failure	
Due to Probable cerebral vascular accident	
Due to Probable Hypertension Cardio - vascular disease	
Other Conditions Cardio - sclerotic heart disease. (Include pregnancy within 3 months of death)	

Date of operation 4/24/45.

Major findings of operation:

Benign prostatic hypertrophy

of autopsy: Dr. Lane.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. M. Greenberg M. D.

Address Sinai Hospital (Date signed) 4/28/45.

G28313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G28313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Gladden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 27 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) APR 27 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1945, at 8.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carcinoma Neck Right

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Knight B. McNally M.D. Medical Examiner.
Date signed 4/18/45.

2677 X

628314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

Registered No. 628314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 853 Hollins St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Salgee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL APR 27 1945
18 (a) Funeral director..... Commissioner of Health
(b) Address.....
19 (a) APR 27 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1945, at 7.30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Arteriosclerotic Cardio-vascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Hughes B. Mitchell M.D.
Medical Examiner.
Date signed 4/12/45

5078 X

G28515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G28515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Carey St. (If rural, give definite location)
(e) Citizen of foreign country? W. PERRY St (Yes or No)
If yes, name country

3 (a) FULL NAME George Griffith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 27 1945 (Date rec'd by registrar) (Signature) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 10 50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hos death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 17 1945 7:30 P.M.
(b) Where did injury occur? 115 W. Carey St. W. PERRY St.
(c) Did injury occur at home, on farm, industrial place, in public place? at Home While at work? No
(d) Means of injury Fell down Stairs

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 18 1945

2078

X

628316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

628316
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 N.Eden Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N.Eden Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G.Barton

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Amelia C.Kendal

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Nov.7th,1869

8. AGE: Years 75 | Months 5 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore,Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Sheet metal work

FATHER
12. Name Harry G.Barton
13. Birthplace Baltimore,Md.

MOTHER
14. Maiden Name Isabell League
15. Birthplace Baltimore,Md.

16 (a) Informant Charles F.Barton (Son)
(b) Address 1422 N.Eden Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Avenue,Balto:

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by registrar) APR 27 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-18 1945 to 4/26 1945, and that I last saw h[illegible] alive on 11 AM 1945

Immediate cause of death 4-26-
Mitral Stenosis
Due to

Due to
Myocardial degeneration
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs
4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Miller M. D.
Address 150 W Fayette Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53a

G28317 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 Harlem ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 821 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chas Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mabel Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1884

8. AGE: Years 61 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Charles M. Moore
13. Birthplace Va

MOTHER
14. Maiden Name Nettie Campbell
15. Birthplace Maryland

16 (a) Informant Mrs Mabel Moore
(b) Address 821 Harlem

17 (a) Burial (b) Date thereof April 30, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Joseph G Brady
(b) Address 409 N Mount St

19 (a) (Date received by local registrar) APR 27 1945 (b) Huntington Williams, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24/45 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1945 to 4/24 1945 and that I last saw h alive on 4/24 1945

Immediate cause of death Cerebral Hemorrhage

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Wilcox M.D.

Address 1131 Harlem Date signed 4/24/45

G28318 BALTIMORE CITY HEALTH DEPARTMENT G28318

CERTIFICATE OF DEATH 1316

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 Linden Ave
(c) Hospital or institution: Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Linden Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ~ years

3 (a) FULL NAME Mary Jane David

3 (b) If veteran, name war ~

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ~

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Sept 15-1931

8. AGE: Years 13 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Sabana Oklahoma (Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER
12. Name Bruce David
13. Birthplace Hackett, Arkansas

MOTHER
14. Maiden Name Nassie Dee Moody
15. Birthplace Barling, Arkansas

16 (a) Informant Bruce David
(b) Address 1813 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave., City

18 (a) Funeral director Stewart & Mouten Co.
(b) Address 108 W. North Ave., City

19 (a) ~ (b) ~
(Date rec'd by registrar) Registrar

APR 28 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 7-30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apl 20 1945 to Apl 26 1945 and that I last saw her alive on Apl 26 1945.

Immediate cause of death: Anaemia Some — Duration: Months

Due to: Chronic Nephritis Some — Years

Due to:

Other Conditions: Congenital deformities R. Radius & Feet
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Keown M. D.
Address 1938 Linden Ave Date signed 4/27/45

X over

G28319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G28319
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Avenue,
(c) Hospital or institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Garland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8-2nd. Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Anna Grove Atlee

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abram Atlee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-1-1870

8. AGE: Years 74 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name J. W. Otto Grove
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Aumiller
15. Birthplace Germany

16 (a) Informant Mr. A. Carl Atlee (son)
(b) Address 5603 Mattfeldt Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-28-1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Stewart & Mowen Company.
(b) Address 108 W. North Avenue, City.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25th. 1945 9:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1945 to 4/25/ 1945.
and that I last saw her alive on 4/25/ 1945.

Immediate cause of death	Duration
Cerebral Hemmorhage	about 1mo.
Due to Arteriosclerosis	unknown
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Mengert M.D.
Address 401 E. 25th. St. Date signed 4/26/45.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28320 — CERTIFICATE OF DEATH — 94a — G28320

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3301 Woodland Ave 16 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 d. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Rev. George A. Ogg

If U. S. Veteran specify WAR

(a) Residence: No. 3301 Woodland Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Norma E. Englar Ogg

6. DATE OF BIRTH (month, day, year) April 15 1867

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
78	0	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Minister

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Mrs. Norma E. Ogg
(Address) 3301 Woodland Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Woodlawn Date 4-29 1945

19. UNDERTAKER Loring Byers
(Address) 5005 Park Heights Ave.

20. FILED ..... 19..... (Signature of Registrar)

APR 27 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Apr. 26, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec. 29 1944 to Apr. 26 1945

I last saw him alive on Apr. 26, 1945. Death is said to have occurred on the date stated above, at 1:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary thrombosis	Apr. 25/45
Angina pectoris	Dec. 1944
Generalized Arterio-sclerosis	

Was an operation performed? no Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Sherman R. Hantz, M. D.
(Address) 2601 Monkton Rd

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28321

AB-74921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28321 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 9months-29days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

14

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1414 Eutaw Place (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Selby Mary D. Selby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George O. Selby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23,1878

8. AGE: Years 66 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name George Parks

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Ann Stevenson

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 28,1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Miller Lamborn

(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

APR 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26- 1942, to 4-25 1945, and that I last saw h. or alive on 4-25- 1945.

Immediate cause of death: Bronchopneumonia — Duration: 5days

Due to

Due to

Other Conditions: Arteriosclerosis Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No. Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. M. Bullock

Address Bal City Hosp Date signed 4-26-45 M.D.

107

G28322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 94a

G28322

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
5023 Grayson Oak Avenue
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 N. Patrick St.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME Grayson H. Mercer

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Grace Grove Mercer
6.(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) 7-8-1879

8. AGE: Years	Months	Days	If less than one day
65	9	20	....hrs. ....min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)
10. Usual occupation Real Estate + Insurance Agent
11. Industry or business
FATHER 12. Name William Mercer
13. Birthplace Frederick Co. Md.
MOTHER 14. Maiden name Ada Webster
15. Birthplace Frederick Co. Md.
16. Informant Mrs. Herbert Schlenderberg
Address 5023 Grayson Oak Ave. - Balto.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-30-45 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick - Md.
18. Funeral director C. E. Cline + Son
Address Frederick - Md.
19. APR 28 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28th 1945, at 4 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17th 1945 to April 28 1945
and that I last saw him alive on April 27th 1945

Immediate cause of death
11 Coronary Thrombosis
(Primary or antecedent)
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION: 11 days

Major findings of operations none Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Earl L. Chambers, M. D. or other
Address 4105 Liberty Hts. Date signed 4/28/45

G28323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28323 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3/4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Fabian F. Levy

3 (b) If veteran, name war: World War #I

3 (c) Social Security Account No. 197-01-5243

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Mrs. Edith M. Levy
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 2, 1886

8. AGE: Years	Months	Days	If less than one day
58	9	25	hr. min.

9. Birthplace Pennsylvania (Phila.)
(Town, county, and state)
10. Usual Occupation Statistician
11. Industry or business

FATHER
12. Name Max Levy
13. Birthplace Detroit, Michigan

MOTHER
14. Maiden Name Diana Franklin
15. Birthplace Washington D.C.

16 (a) Informant Mr. Howard Levy
(b) Address Wayne Ave. & Berkeley St. Philadelphia, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/27/45 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 28 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1945, to April 27 1945, and that I last saw h alive on April 27 1945.

Immediate cause of death	Duration
Cardio - Respiratory Failure	
Due to Coronary Thrombosis	
Due to Coronary Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Crane M. D.
Address Union Memorial Hosp. Date signed 4-28-45

X CRANE

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6385324

BALTIMORE CITY HEALTH DEPARTMENT

AB-92743

CERTIFICATE OF DEATH 61

Registered No. 6385324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Lawson Dunaway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21- 1883

8. AGE: Years 62 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bill (D)

13. Birthplace Va.

MOTHER 14. Maiden Name Liza (D)

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 4/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fredericksburg
Location Va

18 (a) Funeral director Garrett & L. Bramble
(b) Address 106 W Montgomery St

19 (a) 4-30-1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 7.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24- 1945 to 4-24 1945, and that I last saw h. 1m alive on 4-24- 1945.

Immediate cause of death
Pneumonia
Myocardial insufficiency
Due to Mild Diabetes Mellitus
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
4 Hrs
2
3

Date of operation
Major findings of operation: Gas gund Pneumonia - Myocardial
of autopsy Lobular Diabetes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Peary MD

Address Baltimore City Hosp. Date signed 4/28/45

VS 150

G28325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G28325

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Argyle Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arwilda Aquiller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7, 1862

8. AGE: Years 82 | Months 4 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Elizabeth Jewell
(b) Address 1005 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mal. Francis A. Dunkley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Wilson Building

APR 28 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 26 1945 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12/45 to 4/26/45 and that I last saw h[illegible] alive on 4/26/45

Immediate cause of death (a) Pneumonia. Duration 9 Days

Due to for the last 2 yrs. deceased

Due to Arthritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Sellers

Address 504 Med. Arts Bldg. Date signed 4/26/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56F

628526 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St.
(c) Hospital or institution: Union Memorial Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 21 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Harrison Blvd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Melba Browning

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1943

8. AGE: Years 1 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Howard J. Browning
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mary C. Maley
15. Birthplace Md

16 (a) Informant Mrs. Mary C. Browning (mother)
(b) Address 2307 Harrison Blvd City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 28 45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (b)

APR 28 1945

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945 at 6 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1945 to April 27 1945 and that I last saw h[illegible] alive on April 27 1945

Immediate cause of death: Cardio-Respiratory failure, etiology Unknown — Duration

Due to: Congenital Hemangiomata

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation April 27, 1945

Major findings of operation: Hemangioma of scalp.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchijah Spragins

Address U.M.H. Date signed 4-27-45 M D

X

G28327 G28327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Morristown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Castner

3 (b) If veteran, name war: Merchant Marine

3 (c) Social Security Account No. 147-01-2787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1910

8. AGE: Years	Months	Days	If less than one day
35	1	23	hr. min.

9. Birthplace Chester N.J. (Town, county and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER 12. Name Arthur H. Castner

13. Birthplace N.J.

MOTHER 14. Maiden Name Catherine Lacy

15. Birthplace N.J.

16 (a) Informant Arthur H. Castner

(b) Address Chester N.J.

17 (a) Removal (b) Date thereof Apr 28/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Presbyterian Cem
Location Fairmount N.J.

18 (a) Funeral director Philip Sturm's Sons

(b) Address 2124 Eutaw St

19 (a) APR 28 1945 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945 at 6 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Scatena M.D.
Medical Examiner.
Date signed April 27 1945

G28328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G28328

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3144 Kenwick Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3144 Kenwick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary L. Culp.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife John F. Culp.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 27 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Peter K. Baker.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E. Reibold.
15. Birthplace Maryland.

16 (a) Informant Louis F. Culp.
(b) Address 3144 Kenwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Middletown
Location Balto Co. Md

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Christmas Ave

19 (a) APR 28 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945, at 2.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1943 to April 27 1945 and that I last saw her alive on April 27 1945.

Immediate cause of death

	Duration
Chronic Myocarditis	indy
Due to	
Due to	
Other conditions Arteriosclerosis & Chronic Nephritis	indy

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Culp M.D.
Address 1120 W. 25th St. Date signed Apr 28 45

G28329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G28329

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33 to Calvert st

(c) Hospital or institution: Union Memorial Hospital 1/2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 327 West 30th St. Balto. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ellsworth Lee Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1907

8. AGE: Years 37 | Months 9 | Days 9 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Warehouse Man

11. Industry or business

FATHER 12. Name Willard Daniels

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Bessie Moreton

15. Birthplace Virginia

16 (a) Informant Mrs. Bessie Williams.

(b) Address 327 West 30th St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Chenowith & Donovan

(b) Address 445-17 Chestnut Ave

19 (a) APR 28 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1945, to 4-27-1945, and that I last saw him alive on 4-27-1945

Immediate cause of death Cardiorespiratory failure. — Duration

Due to Intestinal obstruction

Due to Carcinoma of sigmoid.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-24-45

Major findings of operation: Carcinoma sigmoid - low intestinal obstruction

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul S. Greene M.D.

Address Union Memorial Hospital Date signed 4-27-45

VS 150

X

628330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

628330 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 N. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Virginia Hare ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1885

8. AGE: Years 59 60 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Deal. River, Md. (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Leopold B. Trigg
13. Birthplace Deal River, Md.

MOTHER
14. Maiden Name Caroline ??
15. Birthplace Deal River, Md.

16 (a) Informant Mrs. Emma Lattig
(b) Address 1609 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Wm. H. Howard
(b) Address 1631 Druid Hill Ave.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) APR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24/45 19 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24/45 19 to 4/24/45 and that I last saw h[illegible] alive on 4/24/45

Immediate cause of death Lung Pneumonia, hypostatic

Due to Pneumonia

Due to " "

Other Conditions Hypertension Cerebral Hemorrhage

Date of operation

Major findings of operation

of autopsy

Duration: Years 1 | Months | Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Barksdale M. D.
Address 524 N. Carey St. Date signed 5/27/45

130

G28331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G28331

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude M. Manger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife late William E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21st 1925

8. AGE: Years	Months	Days	If less than one day
20	1	6	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Typist

11. Industry or business Copper Co.

FATHER
12. Name Vernon W. Leligman
13. Birthplace Penn.

MOTHER
14. Maiden Name Gertrude M. Tebo
15. Birthplace West, Va

16 (a) Informant Mrs Gertrude M. Leligman
(b) Address 2133 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director John J. Conway Son
(b) Address 701-03 Pollitt St

19 (a) APR 28 1945 (Date received by registrar) (b) Huntington Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27th 1945, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head & neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-26 or 27-45 Between 8:20 P.M. & 1:30 A.M.
(b) Where did injury occur? 3012 W. North Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Homicide by shooting

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 4-27-45

VS 151

G28332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G28332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31 St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 W. 15 St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Martinson

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1897

8. AGE: Years	Months	Days	If less than one day
47	5	26	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Sea-faring

FATHER
12. Name Alexander Martinson
13. Birthplace Russia

MOTHER
14. Maiden Name Alma
15. Birthplace Russia

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore 11, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 28/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Tilly & Galanda
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1945, to April 23 1945, and that I last saw h im alive on April 23 1945

	Duration
Immediate cause of death Bronchopneumonia, terminal	2 days
Due to Carcinoma of the left kidney with metastasis in the liver and both lungs	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none done
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. F. Jones M. D.
Address Baltimore, Md. Date signed 4/24/45

US Marine Hospital

G28333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G28333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Inglewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Condito Barsotti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louise E. —

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 31-1881

8. AGE: Years 63 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace: Italy (town, county, and state)

10. Usual Occupation: Plaster Moulder

11. Industry or business

FATHER
12. Name: Giorgnni Barsotti
13. Birthplace: Italy

MOTHER
14. Maiden Name: Christina Brunisso
15. Birthplace: Italy

16 (a) Informant: Mrs. Mary F. Maguire
(b) Address: 2904 Inglewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4- -45 (month) (day) (year)
(c) Cemetery or crematory: Moreland PK.
Location: Balto

18 (a) Funeral director: Leonard J. Luck
(b) Address: 5805 Harford Rd

19 (a) (Date rec'd by Registrar) APR 28 1945 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27-45 19 , at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1945, to 4-27 1945, and that I last saw h[illegible] alive on 4-26 1945.

	Duration
Immediate cause of death (sudden) ? pul embolism	3 min
Due to Antonitis - intestinal adhesions	3 mos
Due to inguinal hernia	3 years
Other Conditions ? Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation 4-10-45

Major findings of operation: adhesions multiple areas obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Norton Bunner M. D.
Address: W. B.G. H. Date signed 4-27-45

X

G28334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G28334 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonvand Wilkens Ave
(c) Hospital or institution: St Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2653 Lehman Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Rudolph Gosewisch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie Wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1904

8. AGE: Years 40 Years | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Western Welding

FATHER 12. Name Gosewisch, Louis

13. Birthplace Germany

MOTHER 14. Maiden Name Haller, Sophie

15. Birthplace Germany

16 (a) Informant Mrs Rudolph Gosewisch

(b) Address 2653 Lehman st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Oakes Mk

18 (a) Funeral director George A Fahey

(b) Address Fulton & Fayette

19 (a) APR 28 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1945, at 2:44 M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/26 1945 to 4/27 1945 and that I last saw h[illegible] alive on 4/27 1945

Immediate cause of death: Confluent Lobular pneumonia — Duration

Due to: Fatty Degeneration of Liver

Due to: Chronic Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: same as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.

Address St. Agnes Hosp Date signed 4/27/45

VS 150

G28335 G28335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inserted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 W. North ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 W. North ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Manger, Jr.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1922

8. AGE: Years	Months	Days	If less than one day
23	3	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk, Rivera Copper R.
11. Industry or business Copper.

FATHER
12. Name Wm. E. Manger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Irene A. Bennett
15. Birthplace Md.

16 (a) Informant Wm. E. Manger
(b) Address 1918 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto. Co. Md.

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) APR 28 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27th 1945 at 2:31 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-26 or 27-1945 Between 5:30 p.m. & P.M.
(b) Where did injury occur? 3012 W. North ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
Means of injury Suicide by shooting

23. Signature Howard J. Norris M.D.
Medical Examiner.
Date signed 4-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

628336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 W. Coldspring Lane
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Mt. Pleasant Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Lee Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Bessie Snyder

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1887

8. AGE: Years 57 | Months 8 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Auto Dealer

11. Industry or business

FATHER
12. Name Edward W. Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amanda French
15. Birthplace Va.

16 (a) Informant Harry Lee Thompson, Jr.
(b) Address 3041 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

APR 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945, at 4.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...,
and that I last saw h[illegible] alive on 4-26 1945.

Immediate cause of death: Apnea following exploration for pancreatic head lesion

Due to: Carcinoma of pancreas with marked retardation in the

Due to: Veno-portal thrombosis

Antecedent causes: secondary to the

Other Conditions: carcinoma

(Include pregnancy within 3 months of death)

Date of operation 4-25-45

Major findings of operation: Carcinoma of pancreas and duodenum

of autopsy:

Duration
days
days
days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward D. Johnson M. D.

Address 1123 St. Paul St. Date signed

X

G28537 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G28537

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 N. Charles St.
(c) Hospital or institution: none 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 N. Charles St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Priscilla Paca Hoblitzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Oliver O'D. Hoblitzell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1869

8. AGE: Years	Months	Days	If less than one day
76	--	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John P. Paca
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Keys
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eliza H. Linthicum
(b) Address 2318 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Lorraine
Location Windsor Mill Rd.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

APR 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1945, to 4/27 1945, and that I last saw her alive on April 27 1945

Immediate cause of death: Coronary Thrombosis — Duration 7 days
Due to: Arteriosclerosis & Hypertension — unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town). (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frances W Gluck M. D.
Address 715 Park Ave. Date signed 4/27/45

Dr. Gluck X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G28338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No. G28338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3045 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3045 W. North.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REGINA DAMERON

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Chas W. Dameron
6 (c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): May 1881
8. AGE: Years: 63 | Months: 11 | Days: | If less than one day: hr. min.
9. Birthplace: Hoboken N.J.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Wm. Phillane
13. Birthplace: Ireland.

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Chas W. Dameron
(b) Address: 3045 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 30 1945 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md

18 (a) Funeral director: Bertram Fox
(b) Address: 2244 N. Charles St.

19 (a) Date received: APR 28 1945 (b) Registrar: Huntington

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature John C. Davis M.D.
Medical Examiner.
Date signed 4/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28339

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G28339
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3937 Keswick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3937 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
ANETTE PARKS LEWIS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lloyd H. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1898

8. AGE: Years 46 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Elisha Parks
13. Birthplace: Md.

MOTHER
14. Maiden Name: Susan V. Treadwell
15. Birthplace: Md.

16 (a) Informant: Mr. Lloyd H. Lewis
(b) Address: 3937 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) APR 28 1945 (b) Entered for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1945 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1945 to 4/25 1945, and that I last saw her alive on 4/24 1945.

	Duration
Immediate cause of death: Carcinoma, brain	4-5 mos
Due to: Carcinomatosis	-
Due to: Carcinoma, breast	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Wm N. McFaul Jr., M. D.
Address 1800 N. Charles St. Date signed 4/27/45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(Registered No.) 126 (28340)

G28340

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Howard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Moffatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah C. Moffatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-1870

8. AGE: Years 74 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Niagara N. Y. (Town, county, and state)

10. Usual Occupation Shoe Inspector

11. Industry or business

FATHER 12. Name John Henry Moffatt
13. Birthplace N. Y.

MOTHER 14. Maiden Name Arina Hughes
15. Birthplace N. Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto.

18 (a) Funeral director Wm. J. Tichenor & Sons
(b) Address Balto. [illegible]

19 (a) [illegible] (Local Registrar) (b) [illegible] Registrar

APR 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 45, at 1 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1944 to April 26 1945 and that I last saw him alive on Apr. 26 1945.

Immediate cause of death	Duration
(a) Uremia Arteriosclerosis	
Due to (b) Poor renal function following operative procedures	6 mos.
Due to (c) Cystolithiasis	
Other Conditions Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 11/6/45 and 11/24/45

Major findings of operation: As above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Storey
Address Johns Hopkins Hosp Date signed 4/30/45

X

G28341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

Registered No. G28341

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5307 Tilbury Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5307 Tilbury Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GERALD P. HOPKINS

3 (b) If veteran, name war: World War #I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estelle McDonough Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1895

8. AGE: Years 50 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Harwood, Md. (Town, county, and state)

10. Usual Occupation Vice President

11. Industry or business Commercial Credit Co.

FATHER
12. Name John T. Hopkins
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Frances Pollard
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Estelle Hopkins
(b) Address 5307 Tilbury Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Willis, M.D. Registrar

VS 150 APR 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945, at 2:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 45 to April 27 19 45 and that I last saw h. alive on April 26 19 45.

Immediate cause of death: Cachexia — Duration: 4 mos.

Due to: Probably a carcinoma of the retroperitoneal glands — Duration: 18 mos.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Approx. a year ago

Major findings of operation: Tumor of retroperitoneal gland of undetermined type

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Franklin E. Lehr M. D.

Address 1115 E. Pond St Date signed 4/28/45

628342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

628342 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1053 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1229A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Katie B.
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec. 11 1876

8. AGE: Years	Months	Days	If less than one day
68	4	15	hr. min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura
15. Birthplace Maryland

16 (a) Informant Kate B. Johnson (W)
(b) Address 1053 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) APR 28 1945 (b) (Date received by registrar) Registrar

VS 151

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 4-26-45

G28643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. 28343

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 S. Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Ann ~~Schultz~~ Schulley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30-1944

8. AGE: Years	Months	Days	If less than one day
—	6 mos	8	hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Frederick Schulley
13. Birthplace Germany

MOTHER
14. Maiden Name Mildred Walz
15. Birthplace Balto., Md

16 (a) Informant Mrs. Frederick Schulley
(b) Address 28 S. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director George Lefwat
(b) Address 2101 Frederick Ave.

19 (a) Apr 30 1945 (b) Huntington Williamsport Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945 at 7 57 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 26 1945 to April 28 1945, and that I last saw h. alive on April 28 1945.

Immediate cause of death	Duration
Hydrocephalus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Smythe M.D.
Address Mercy Hosp Date signed Nov 6 45

VS 150

G28344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G28344

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive and 31 St.

(c) Hospital or institution: U.S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mo. 4da.

(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County Tompkinville

(c) City or town Staten Island (If outside city or town limits, write RURAL and give town)

(d) Street No. USCG Liaison Office, Pier 8, U.S. Navy Sec. Base (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ellen Karlson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Karlson

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) March 18, 1913

8. AGE: Years 32 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Sault St. Marie, Mich. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Albert Wendelin

13. Birthplace Sweden

MOTHER

14. Maiden Name Ina Lampin

15. Birthplace Finland

16 (a) Informant Records, US Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 28 1945 (month) (day) (year)

(c) Cemetery or crematory

Location Sault St Marie Michigan

18 (a) Funeral director Pott & B.M. Walter

(b) Address Patterson Park Ave & Huntington Ave

19 (a) Date received by registrar (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 27 1945, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1944, to April 27 1945, and that I last saw her alive on April 27 1945.

Immediate cause of death	Duration
Carcinoma of cervix	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature B.F. Jones M.D.

Address Baltc., Md. B.F. Jones Date signed 4/28/45

VS 100 APR 28 1945

US Marine Hospital

G28345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1702

Registered No. G28345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARRIN RESERVE OR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Chase Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Finney

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-07-6037

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Alice Finney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10 1913

8. AGE: Years 32 | Months 2 | Days 14 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Finney
13. Birthplace Va

MOTHER 14. Maiden Name Emma Duncan
15. Birthplace Va

16 (a) Informant Alice Finney
(b) Address 1833 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29 1945

(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1545 McElderry St

APR 29 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 10 05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured ribs, contusion of liver.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/24/45 at 7-1 7 35 A.M.
(b) Where did injury occur? Monument St & Linwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Auto & Streetcar collided (Private, passenger in auto.)

23. Signature Thomas J. Claudio M.D. Medical Examiner.
Date signed 4-24-45

VS 151

G28346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

G28346 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Lusby
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Weems

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-98.

8. AGE: Years	Months	Days	If less than one day
46	5	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Jefferson
13. Birthplace Md.

MOTHER 14. Maiden Name Martha Hutchins
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Calvert Co

18 (a) Funeral director P E Sewell
(b) Address Prince Frederick Md

19 (a) APR 9 1945 Huntington Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 28 1945 at 12 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 28 1945 to APRIL 28 1945 and that I last saw her alive on APRIL 28 1945

Immediate cause of death PULMONARY EDEMA
HEART FAILURE

Due to -UREMIA

Due to

Other Conditions INTEST. OBSTRUCTION
& MESENTERIC THROMB
(Include pregnancy within 3 months of death)

Date of operation APRIL 25 45

Major findings of operation: about 6 feet gangrenous ileum & resection

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L Lewis Jr. M. D.
Address c/o JHH Date signed 4-28-45

X

G28347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28347 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Beaumont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 84 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Beaumont Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Elizabeth Benzinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1860

8. AGE: Years	Months	Days	If less than one day
84	7	5	--hr. ---min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John S. Benzinger
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Elizabeth Eisler
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Mary Elizabeth May
(b) Address 511 Beaumont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meakes and Son
(b) Address 805 N. Calvert Street

APR 28 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945, at 6-30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1945, to April 27 1945, and that I last saw h[er] alive on April 27 1945.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 1 Day
Due to: Bronchio-Pneumonia — 4 days
Due to: ---
Other Conditions: Cerebral Hemorrhage — 2 days

(Include pregnancy within 3 months of death)
Date of operation ---
Major findings of operation: ---
of autopsy: ---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide~~, or homicide ---
(b) Date of occurrence ---, at ---, M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ---
(e) Means of injury ---

23. Signature John A. Hammar
Address 11 E. Lexington Street Date signed 4/28/45

AB-95144 G28348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G28348 Registered No. 13 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N.Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Wood or Minnie E. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11-1907

8. AGE: Years	Months	Days	If less than one day
37	4	14	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Aldis Smith (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Tinsley (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 28/45 (month) (day) (year)
(c) Cemetery or crematory Clifton Forge Va
Location Virginia

18 (a) Funeral director W. Dillian Cook Inc
(b) Address 217 E. Fayette Street
Registering for Williams, M.D.

19 (a) 29 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25- 1945, at 1.40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16- 1945, to 4-25- 1945, and that I last saw her alive on 4-25- 1945.

Immediate cause of death	Duration
Empyema	?
Due to Pulmonary tuberculosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon
Address Balto City Hosp. Date signed 4/27/45 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the exact age is especially important. Give the causes of death clearly and legibly.

G28349 BALTIMORE CITY HEALTH DEPARTMENT 97 Reg. No. G28349

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Samuel Goldman
13. Birthplace Poland

MOTHER
14. Maiden Name Sarah Mitnick
15. Birthplace Poland

16 (a) Informant William Davis
(b) Address 3908 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received Apr 29 1945 (b) Registrar Washington Williams Reg. M.

VS 150

MEDICAL CERTIFICATION 7.20

20. DATE OF DEATH April 26 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to 4/26 1945.
and that I last saw h. alive on 4/26 1945.

Immediate cause of death: Cerebral hemorrhage

Duration: 7 days

Due to

Due to

Other Conditions Chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Meth Bikur

Address 2904 Rest Rd Date signed 4/27/45

X

G28350 BALTIMORE CITY HEALTH DEPARTMENT G28350

CERTIFICATE OF DEATH 183

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 A Duncan St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Sweeting

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1929

8. AGE: Years	Months	Days	If less than one day
15	8	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation clerk

11. Industry or business

FATHER
12. Name George Sweeting
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jeanne Sadowski
15. Birthplace Bridgeport, Conn.

16 (a) Informant Jeanie Kreczmer
(b) Address 106 S. Duncan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director W. W. E. Dippel's Son
(b) Address Gomboard & Ann Sts.

19 APR 29 1945 (b) Hampton Williams, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28- 1945; at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at 4-1 ? M.
(b) Where did injury occur? Harbor, Pier 6 Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Found drowned

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1930

628351 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3415 Fallstaff Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Fallstaff Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Stern Kahn

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19,1864

8. AGE: Years	Months	Days	If less than one day
80	9	9	hr. min.

9. Birthplace New Orleans, Louisiana
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Stern
13. Birthplace Germany

MOTHER
14. Maiden Name Annette Newman
15. Birthplace New Orleans Louisiana

16 (a) Informant Mrs. Gordon Goldsmith
(b) Address 3415 Fallstaff Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/29/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rest
Location New Orleans Louisiana

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) APR 29 1945 (Date rec'd by registrar) (b) Hattie Wilson Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28/ 1945, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1930, to 4/28/ 1945, and that I last saw her alive on 4/28/ 1945.

Immediate cause of death	Duration
Heart block, Coronary Occlusion,	2 days
Due to Hypertensive, Cardiovascular	10 years
Due to Disease.	15 years
Other Conditions Gall Stones	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore H. Morrison M. D.
Address 11 E. Chase St Date signed 4/29/45

Dr. Keown
1938 Linden Ave

628352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

628352 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Gibbons Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 7 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Gibbons Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy M. Griswold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frank R. Griswold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1862

8. AGE: Years	Months	Days	If less than one day
83	1	8	hr. min.

9. Birthplace Guilford, Connecticut
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Eleazer Woodruff
13. Birthplace Conn.

MOTHER
14. Maiden Name Harriett Davis
15. Birthplace Conn.

16 (a) Informant Mrs. John J. Hughes
(b) Address 3602 Gibbons Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory Alderbrook
Location Guilford, Conn.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 29 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28th, 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Apl 28 1945 and that I last saw h-er alive on Apl 17 1945.

Immediate cause of death	Duration
Chr. Myocarditis	Usual Years
Due to Chronic Arteria Sclerosis	Usual Years
Due to Old age	
Other Conditions Severe minor Cerebral Hemorrhages	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Keown
Address 1938 Linden Ave Date signed 4/28/45

VS 150

X

G28353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28353 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Sarah Eisenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Jos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Chas Lurie

13. Birthplace R.

MOTHER 14. Maiden Name Chassa

15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4-29-45 (month) (day) (year)

(c) Cemetery or crematory Wash. Blvd

Location Wash Blvd

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore St

APR 29 1945 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28-45 19... at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1945 to 4/28 1945 and that I last saw her alive on 4/28 1945

Immediate cause of death Cerebral Hemorrhage — Duration 5 days

Due to Hypertension — 5 yrs

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A Cohen

Address 2145 W Balto Date signed 4/28/45 M.D.

X

G28354 G28354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 Patapsco St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Patapsco St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L Kyle

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clarence Kyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1883

8. AGE: Years 61 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Hardy
13. Birthplace Bal. Co. Md.

MOTHER
14. Maiden Name Helen R. Hatten
15. Birthplace Md

16 (a) Informant Margaret M. Tucker
(b) Address 2531 Calverton Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto City

18 (a) Funeral director E. Howard Evans
(b) Address 440 Patapsco St Huntingdon Station, Md

19 (a) (b) (Date received by registrar) Registrar

28 1945

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945 to April 25 1945, and that I last saw h[illegible] alive on April 23 1945.

Immediate cause of death: Cardiac failure — Duration: 1 week

Due to:

Due to:

Other Conditions: Arteriosclerosis C.V.D.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lord Schaffer
Address Mt Airy Md Date signed 4 28 1945

G28355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/187

G28355 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. W 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6218 Elliott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loy D. Lewing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Esther Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1916

8. AGE: Years	Months	Days	If less than one day
28	9	1	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Burner at Fairfield
11. Industry or business Ship yards

FATHER
12. Name Lydie O Lewing
13. Birthplace N C

MOTHER
14. Maiden Name Vesie May Bowman
15. Birthplace N C

16 (a) Informant Lydie O Lewing
(b) Address Neelsville, N. C.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof May 1st/45 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Neelsville, N. C.

18 (a) Funeral director John E Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) APR 29 1945 (Date rec'd by registrar) (b) Lexington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 6 45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 28 1945 5 40 P M.
(b) Where did injury occur? Broadway & Lancaster St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Blow [illegible] during riot

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed April 29 1945

G28356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G28356 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fabiszak

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) July 25, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name William Wesolowski
13. Birthplace Poznan, Poland

MOTHER 14. Maiden Name ---- Lewandowski
15. Birthplace Poznan, Poland

16 (a) Informant Mr. Joseph Fabiszak
(b) Address 1911 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Ave

(c) (Date received by registrar) APR 29 1945 (b) Huntington Williams, Registrar D

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945, at 4 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1943 to Apl 27 1945 and that I last saw her alive on Apl 27 1945

Immediate cause of death Hypertensive C-V. Disease
Coronary Thrombosis
Due to Cerebral Hemorrhage
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

Duration
12-3-43
3-1-45
4-16-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eastheimer M. D.
Address 842 S Eastern Ave Date signed 4-28-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28357 / 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 S. Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 S. Ann Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Pawlak

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1873

8. AGE: Years	Months	Days	If less than one day
71	10	15	hr. min.

9. Birthplace Poznan, Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name --- Soltysiak
13. Birthplace Poznan, Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Albert Pawlak
(b) Address 2736 E. Preston Street

17 (a) Burial (b) Date thereof 4/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski Sons
(b) Address 1808 Eastern Ave

19 (a) 4-30-1945 (b) Clayton Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1945, to 4/25 1945; and that I last saw her alive on 4/25 1945

Immediate cause of death Coronary occlusion — Duration 3 days
Due to Coronary heart disease — ?
Due to Diabetes — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Max Feinfeder M. D.
Address 20 W. Ratt St. Date signed 4/27/45

Spec.—5-16-39—L. F. S.—100 Blks.

G28358 HEALTH DEPARTMENT—CITY OF BALTIMORE G28358

CERTIFICATE OF DEATH 13B

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1411 Hanover ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Louis Hatchell, Jr.

(a) RESIDENCE NO. 1411 Division Lt. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Maritime Service

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Joseph Louis Hatchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boydton, Virginia

12 MAIDEN NAME OF MOTHER Bessie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boydton, Va.

14 Informant Mrs. Reggie S. Hatchell

(Address) 1411 - Division St.

15 APR 30 1945 Filed Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1945

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1944 to April 26, 1945 that I last saw him alive on April 26, 1945 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

Tuberculous Meningitis

(duration) 2 yrs. 3 mos. — da.

CONTRIBUTORY (Secondary) T.B. Meningitis (duration) yrs. mos. 21 da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Test.

(Signed) [illegible], M. D.

4-26 1945 (Address) 122 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burial - Arbutus Md	4/29/1945

20 UNDERTAKER Mrs. George H. Holland ADDRESS 1631 Druid Hill Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL- 628359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28359 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2h.15 m.

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 316 W. Hoffman St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Viola Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1880 ?

8. AGE: Years	Months	Days	If less than one day
65 ?	?	?	hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name ?

13. Birthplace Ala.

MOTHER

14. Maiden Name Eliza Price

15. Birthplace Ala.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof H. 30. 1945 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Wm. Geary & Sykes

(b) Address 603 Dulaney Valley Rd

19 20 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 3.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1945 to April 26 1945, and that I last saw h[illegible] er alive on April 26 1945.

Immediate cause of death Cardiac decompensation — Duration ?

Due to Hypertensive cardiovascular disease — ?

Due to — ?

Other Conditions Generalized arteriosclerosis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. M. Phillips

Address Balt. City Hosp. Date signed 4-28-45 M.D.

G28360 BALTIMORE CITY HEALTH DEPARTMENT ✓ G28360

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 823 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wm. G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1874

8. AGE: Years 66 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Cooper
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Lyndia Carroll
15. Birthplace Mississippi

16 (a) Informant Charles Capsolo Owen
(b) Address 1131 N. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30. 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Filed for William M. Date rec'd by registrar Registrar

Vs 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945 to April 27 1945, and that I last saw h[illegible] alive on April 27 1945.

Immediate Cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis & Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. G. Bagley

Address 844 N. Carey St. Date signed 4/28/45 M. D.

G28361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered G28361

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Alfred Hunter Butler

3 (b) If veteran, name war W

(c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Ida Mae Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/10/874

8. AGE: Years	Months	Days	If less than one day
70	6	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business

FATHER
12. Name Mr. John Hunter Butler
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Manuella Woodward
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Northern Md

18 (a) Funeral director Pellman Funeral Home
(b) Address 1219 E. Fort Ave

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to April 29 1945, and that I last saw him alive on April 29 1945.

Immediate cause of death Cardiorespiratory Failure — Duration

Due to Carcinoma of Rectum with metastases

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 4/29/45 M. D.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G28362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Eutaw
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Third St. (Brooklyn)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Pilock

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret Pilock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13th 1909

8. AGE: Years	Months	Days	If less than one day
35	4	15	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Ameo Corp.

FATHER
12. Name Jacob Pilock
13. Birthplace Md.

MOTHER
14. Maiden Name Columbia Colvin
15. Birthplace Md.

16 (a) Informant Mrs. Margaret Pilock
(b) Address 3525 Third St.

17 (a) Burial (b) Date thereof 5/3/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) APR 30 1945 (b) Livingston Williams, M.D.
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1945, to 4/28 1945; and that I last saw him alive on 4/27 1945

Immediate cause of death: Atypical Pneumonia — Duration 3 wks
Pulmonary Infarction — 3 wks
Due to: Rheumatic Heart Disease with Mitral Stenosis — 15 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strautel M. D.
Address Md. Gen. Hospital Date signed 4/28/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No. 628363

628363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles W. Hunt

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mary Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, y): Aug 30 1872

8. AGE: Years	Months	Days	If less than one day
72	7	27	hr. min.

9. Birthplace: W. Va. (Town, county, and state)
10. Usual Occupation: Watchman
11. Industry or business: Pollock Co.

FATHER
12. Name: Crula Hunt
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: W. Va.

16 (a) Informant: Mary Hunt
(b) Address: 318 N. Fulton Ave

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Savage Md.
Location

18 (a) Funeral director: William Cook Inc
(b) Address: 1427 St. Paul St

19 APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945, at 8½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 – 1945, to April 26 1945, and that I last saw h[illegible] alive on April 26 1945.

Immediate cause of death: Cerebral Thrombosis — Duration: 15 min.
Due to: arteriosclerosis — 1 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Gilbert K. Mortimer Jr M. D.
Address 2706 St Paul. Date signed 4/28/45

628364
AB-93122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 5 P C

628364
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alstine Hall, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24-1941

8. AGE: Years	Months	Days	If less than one day
4	2	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alstine Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Smith
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary cem
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave, Balto, Md

19 APR 30 1945 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27- 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14- 1945 to 4-27 1945 and that I last saw him alive on 4-27 1945

Immediate cause of death: Acute Myocarditis — Duration: 1 day

Due to: Rheumatic fever — 2 wks

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter M Treem M. D.
Address B. C. H. Date signed 4-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6285̸65

CWK-93182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1602

Registered No. 6285̸65

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Hrs-35 Min.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1317 W. Fayette Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1945

8. AGE: Years	Months	Days	If less than one day
			8 hr. 35 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Jessie Gordon

13. Birthplace ?

MOTHER

14. Maiden Name Irene Harris

15. Birthplace Virginia

16 (a) Informant Records: Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) [illegible], cremation, [illegible] (b) Date thereof Apr. 24th, 1945 (month) (day) (year) at 9 A.M

(c) [illegible] crematory

Location 4940 Eastern Ave

18 (a) Funeral director Baltimore City Hospitals

(b) Address (Records

19 APR 30 1945 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945, to April 18 1945, and that I last saw h im alive on April 18 1945.

Immediate cause of death	Duration
INTRACRANIAL Hemorrhage	8 Hrs.
Due to Birth Injury	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature N. B. Penry, Jr. M.D.

Address Balto. City Hosp. Date signed 4/30/45

G28366
472655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

Registered No. G28366

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Sterling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Holley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-85

8. AGE: Years 60 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Porter Food Fair

11. Industry or business

FATHER
12. Name James Holley.
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Frazier
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) V (Burial, cremation, or removal) (b) Date thereof 5-1-45 (month) (day) (year)
(c) Cemetery or crematory Scotland
Location St Marys Co Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

APR 30 1945 (Date rec'd by registrar) (b) Huntingtown Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945 at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to April 28 1945 and that I last saw him alive on April 28 1945

Immediate cause of death Respiratory Failure — Duration

Due to Carcinomatosis

Due to Carcinoma of G-I tract

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 24, 1945

Major findings of operation: Carcinomatosis and gastro-colic fistula

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard F. Kuttner Jr. M.D.
Address Johns Hopkins Hosp. Date signed 4-29-45

VS 150

628367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

628367 Registered No.

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 132 W. Lafayette Ave.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 W. Lafayette St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Oberndorf

3 (b) If veteran, name war ---

3 (c) Social Security Account No. -----

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel Oberndorf

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1861

8. AGE: Years: 84 | Months: 3 | Days: 7 | If less than one day: ____hr. ____min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: Allen Martin
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Elizabeth Stewart
15. Birthplace: Ireland

16 (a) Informant: Mr. Allan Hammar
(b) Address: 1804 Kenway road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location

18 (a) Funeral director: Chas J. Graves & Son
(b) Address: 118 N. Mt. Royal Ave

19 (a) APR 30 1945 (Month, day) registered. Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic CV disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature: P. S. Sulenski M.D.
Medical Examiner.
Date signed 4/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

942

G28368 Registered No.

1. PLACE OF DEATH: D.A.
(a) Baltimore City, Maryland
(b) Street address Wyman Park Apts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 1944 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14th 1873

8. AGE: Years 71 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Nursesing

11. Industry or business Private

FATHER
12. Name Michael O. Hanlon
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Drew
15. Birthplace Ireland

16 (a) Informant Joseph Woods
(b) Address 2403 E Lafayette Ave

17 (a) Burial (b) Date thereof May 1st 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo F. Leak
(b) Address 1201-03 N. Patterson Park Ave

APR 30 1945
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Robinson M.D.
Medical Examiner.
Date signed 4/30/45

G28369 Olschefski ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G28369

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 605 S. Kenwood Ave

(c) Hospital or institution: Saint Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 605 S. Kenwood

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Virginia Olschefski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William A.

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Nov 7 - 1910

8. AGE: Years	Months	Days	If less than one day
34	5	20	..... hr. ..... min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Peter Dombrowski

13. Birthplace Poland

MOTHER

14. Maiden Name Laura Buck

15. Birthplace Poland.

16 (a) Informant Wm. A. Olschefske

(b) Address 605 S. Kenwood Ave

17 (a) Burial (b) Date thereof May 2-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson Street

19 (a) Apr 30 1945 Huntington for Williams

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1945 at 1 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1945 to 4-27 1945 and that I last saw her alive on 4-27 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic pulmonary disease.	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 4-29-45

VS 190

G28370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G28370

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 S Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S. Montford ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joseph Stromer

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-4665

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct 3-1881

8. AGE: Years 63 | Months 6 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Stromer
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Barbara Riegel
15. Birthplace Balto Md.

16 (a) Informant Mary Stromer (wife)
(b) Address 603 S Montford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) APR 30 1945 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 27 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to Apr 27 1945 and that I last saw h.. alive on Apr 26 1945

Immediate cause of death Chr. Myocarditis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1941

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Kaufman M. D.

24. Address 350 S Balto Date signed Apr 29 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G28371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 W Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie May Sewell

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Irvin S. Sewell
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 2. 1890

8. AGE: Years	Months	Days	If less than one day
54	11	26	hr. min.

9. Birthplace Mardela Springs Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Graham
13. Birthplace Balto Md

MOTHER
14. Maiden Name Christia Myers
15. Birthplace Md

16 (a) Informant Irvin S Sewell
(b) Address 2741 W. Lafayette Ave

17 (a) Burial (b) Date thereof 4/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Orthodox Baptist Cem
Location Mardela Springs Md

18 (a) Funeral director Guy H Keeney
(b) Address Fuller & Gibson

19 (a) APR 30 1945 (b) Remington & Hillsdale, Md.
Date received by Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Late death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due
to Multiple Fractures

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 16/6
(a) Date of injury April 27 1945 1:30 P.M.
(b) Where did injury occur? 2741 W. Lafayette Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from 2nd floor porch

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 28 1945.

G28372 Klees

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G28372 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 S. Monroe St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 S Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry J. Klees

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Dec'd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30. 1871

8. AGE: Years 73 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired Saloon
11. Industry or business City of Balto

FATHER
12. Name John J. Klees
13. Birthplace Holland

MOTHER
14. Maiden Name Mary Diede
15. Birthplace Balto Md

16 (a) Informant Mrs Mary Fitzner
(b) Address 324 S Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Thos J Carney
(b) Address Helms & Kilmon

19 (a) (Director of Registrar) (b) Huntington Williams, M.D.

APR 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to April 25 1945 and that I last saw him alive on April 25 1945

Immediate cause of death: Acute Cardiac Dilitation — Duration: Few Days

Due to: Hypertension Cardio-vascular Disease — Duration: ?

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman
Address 713 W. Hoffman St Date signed April 29, 45

X

G28373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28373 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Douglas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Suiter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widow

6 (b) Name of husband or wife Robert Suiter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	4	hr. min.

9. Birthplace Granite, South Richmond
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Woolridge
13. Birthplace Granite S. Richmond

MOTHER
14. Maiden Name Rebecca Nokens
15. Birthplace Granite S. Richmond, Va

16 (a) Informant James E. Woolridge
(b) Address 883 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 222 N Schroeder St

19 APR 30 1945 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1945, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1945 to 4/26 1945, and that I last saw her alive on 4/26 1945

Immediate cause of death Diabetic Acidosis — Duration

Due to

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Woodard

Address Provident Hospital Date signed 4/28/45

VS 150

G28374 ✓ G28374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3811 Boarman Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Boarman Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Maurice E, Morstein

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 216-01-6787

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 12. 1894

8. AGE: Years 50 | Months 7 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business Salesman Butler Bros

FATHER
12. Name Joseph Morstein
13. Birthplace Russia

MOTHER
14. Maiden Name Celia ?
15. Birthplace Russia

16 (a) Informant Ethel Morstein
(b) Address 3811 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth T Filoh Cmetry
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) APR 30 1945 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

VS 150

MEDICAL CERTIFICATION 11.15

20. DATE OF DEATH April 29, 1945, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to April 29, 1945, and that I last saw h. alive on April 27, 1945.

Immediate cause of death: Acute coronary thrombosis — Duration .....
Due to: Arteriosclerosis — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Sidney L. Levy M. D.
Address 2322 Eastern Pkwy Date signed 4/30/45

G28375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28375 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Bateman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Bateman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME EDWARD GRAY TURNER

3 (b) If veteran, name war –

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Myra W. Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1871

8. AGE: Years 73 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)

10. Usual Occupation Builder

11. Industry or business Self

FATHER
12. Name William B. Turner
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Brotherton
15. Birthplace Md.

16 (a) Informant Mrs. Myra W. Turner
(b) Address 3406 Bateman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945, at 9:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1930, to Apr 27 1945, and that I last saw him alive on Apr 26 1945.

Immediate cause of death Ch Myocarditis — Duration June 1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence / at M
(c) Where did injury occur? / / /
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? / (Specify type of place) While at work? /
(e) Means of injury /

23. Signature E. M. McGrane M. D.

Address 105 Med Arts Date signed Apr 30/45

VS 150

628376 Death Cert

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

X ✓ 628376 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert
(c) Hospital or institution: Mercy Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town [illegible] Annex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 Murdock Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** FREDERICK THOMAS HORMES, SR.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-10-5077

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Alice Hormes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-88

8. AGE: Years 56 | Months 10 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Supt. Relief Dept.

11. Industry or business Western Md. R. R.

FATHER
12. Name George Thomas Hormes
13. Birthplace Balto Maryland

MOTHER
14. Maiden Name Lena Tamm
15. Birthplace Maryland (Balto.)

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 30 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1945 to 4-29 1945 and that I last saw h.im alive on 4-29 1945.

Immediate cause of death C.R. failure

Due to Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard P. Grove M. D.
Address Union Memorial Hospital Date signed 4-29-45

X

628577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

628577 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Northern Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Bunting

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 45 Months: Days: If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: B. & O. R. R.

FATHER
12. Name: Charles Henry Bunting
13. Birthplace: -

MOTHER
14. Maiden Name: Dora E. Emrich
15. Birthplace: Germany

16 (a) Informant: Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945 at 3:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed April 27th 1945

G28578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3B

G28578 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4262 Nicholas Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4262 Nicholas Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOHN H. CARTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Irene L. Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1897

8. AGE: Years	Months	Days	If less than one day
47	9	3	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Huber & Co.

FATHER
12. Name Albert R. Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Mary H. Stephens
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Irene L. Carter
(b) Address 4262 Nicholas Ave. 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 30 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1945 at 3:00 am M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12th 1945 to April 28th 1945, and that I last saw h i m alive on April 28 1945.

Immediate cause of death Tuberculosis pulmonary — Duration

Due to

Due to

Other Conditions cirrhosis hepatis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold H. Bix M. D.
Address 2516 Linden Date signed 4-30-45

G28379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G28379

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celestine V Sullivan.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1930

8. AGE: Years 14 | Months 8 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation school girl

11. Industry or business

FATHER 12. Name John Wanamaker

13. Birthplace Phila. Pa.

MOTHER 14. Maiden Name Gertrude Sullivan

15. Birthplace Balto. Md

16 (a) Informant Gertrude Grayson

(b) Address 1207 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location C. C. Co. Md.

18 (a) Funeral director Samuel W. Sullivan Jr.

(b) Address 117 N. Carrollton Ave

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1945, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Cerebral Aneurysm.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh W. B. McNeal, M.D. Medical Examiner.

Date signed 4/30/45.

VS 151

G28380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

831 Registered No. G28380

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 S. Wolfe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 S. Wolf Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANNA SHEPPARD

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 41891

8. AGE: Years 53 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George Schatz
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Seitz
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary Wolf (Daughter)
(b) Address 212 S. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 30 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945 at 1.10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945 to April 26 1945 and that I last saw him alive on April 26 1945

Immediate cause of death: Pulmonary Oedema — Duration: 2 days

Due to

Due to

Other Conditions: Cerebral Hemorrhage, Paralysis Sin (Hemiplegia Sin (Rt)) — Duration: 8 mos?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Harry Sander, M.D.

Address 14 S. Broadway Date signed 4/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G28381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Woodbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Levenson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Julius Levenson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name Russek
15. Birthplace Russia

16 (a) Informant Howard Levenson
(b) Address 2810 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friedale
Location

18 (a) Funeral director Joel Levin Inc
(b) Address 143 E. Balto St

19 (a) (Date rec'd by registrar) APR 30 1945 Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1944 to April 29 1945 and that I last saw her alive on April 28 1945.

Immediate cause of death	Duration
Primary Carcinoma of Ovary	
Generalized Carcinomatosis	
Due to	
Due to	
Other Conditions Arteriosclerotic CVHD	

(Include pregnancy within 3 months of death)
Date of operation 12/11/44
Major findings of operation: Same as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applefeld M.D.
Address 2511 Reisterstown Rd Date signed 4/29/45

VS 130

G28382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83D

Registered No. G28382

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 PK. HGTS. AVE.
(c) Hospital or institution: Mt. SINAI HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) L
(e) Length of stay in Baltimore (yrs., mos., or days) 56

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 REISTERTOWN ROAD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JuLius SchONFELD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Yetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Chas Schonfeld
13. Birthplace Austria

MOTHER
14. Maiden Name —
15. Birthplace Austria

16 (a) Informant Mr. Paul Schonfeld
(b) Address 2301 Annapolis Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friedell
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Interred for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-45 19 .. at 12 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1943 to 4-29 1945 and that I last saw h. alive on 4-28 1945

Immediate cause of death	Duration
Fem. neck of Arteriosclerosis	
Hemiplegia	1 wk
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Feinman

Address 11 E. Chase St. Date signed 4/29/45 M. D.

X

G28383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28383

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 S. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/1900

8. AGE: Years 44 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Charles Wheatley
13. Birthplace Md

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Md

16 (a) Informant Myrtle Wheatley
(b) Address 703 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. B. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (Date rec'd by Local Reg.) APR 30 1945 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 19 45, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1945, to April 28 1945, and that I last saw h alive on April 28 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to Cardiac Insufficiency Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.

Address 803 N. Fremont Date signed

G28384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G28384

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Mosley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-1894

8. AGE: Years	Months	Days	If less than one day
50 51	4	8	hr. min.

9. Birthplace N.C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Mosley
13. Birthplace N.C

MOTHER
14. Maiden Name Rachel Mosley
15. Birthplace N.C

16 (a) Informant Thomas Banks
(b) Address N.C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.R. Co

18 (a) Funeral director Cayser Sanders
(b) Address 1412 E. Preston St

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1945, at 6.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCulloch Medical Examiner.
Date signed 4/26/45

VS 151

G28385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73 D

Registered No. G28385

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 276 N. Exeter St
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 276 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Skerritt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widow

6 (b) Name of husband or wife Randall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	23	hr. min.

9. Birthplace Scotland
(Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name ? Gatewood
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Ga.

16 (a) Informant Anderson Skerritt
(b) Address 1510 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A County, Md.

18 (a) Funeral director Joseph b. Locke, Jr.
(b) Address 1304 N. Central Ave.

19 APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1945, to 4-27 1945, and that I last saw h. alive on 4-24 1945.

Immediate cause of death	Duration
Heart failure	
Due to Cerebral Thrombosis	
Due to Arteriosclerosis.	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris A. Zinn M. D.
Address 11 E. Biddle St. Date signed 4/30/45

95a

G28386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

G28386 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N Lakewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N Lakewood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A Shea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William J Shea

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Wright
13. Birthplace Balto

MOTHER
14. Maiden Name Katherine Schlenker
15. Birthplace Germany

16 (a) Informant Mrs Viola Reisch
(b) Address 425 N Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3/45 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem
Location Balto Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to April 30 1945, and that I last saw h[illegible] alive on April 29 1945.

Immediate cause of death Uremia

Due to Chronic Glomerulo Nephritis

Due to Nephritis

Other Conditions ✓

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation:

of autopsy: ✓

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ✓ at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)
(e) Means of injury

23. Signature Chas F Blake M. D.
Address 20 E Preston Date signed 4/30/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 169

G28387
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Av.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brinkmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/45

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Seigert

15. Birthplace Md.

16 (a) Informant Edwin Brinkmeyer

(b) Address 1808 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin, Lafuze & Sons

(b) Address 1827 W. North Ave.

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1945, to 4/28 1945, and that I last saw him alive on 4/28 1945.

Immediate cause of death	Duration
Atelectasis	
Due to Premature birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin H. Brinkmeyer M.D.

Address St. Agnes Hospital Date signed 4/29/45

VS 150

G28388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G28388

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4663 Park Heights Ave.
(c) Hospital or institution: 27 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4663 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Barbara Emma McCubbin,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George W. McCubbin,
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1871

8. AGE: Years	Months	Days	If less than one day
73	6	19	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Augustus Watts,
13. Birthplace Baltimore City,

MOTHER
14. Maiden Name Anna Riddle,
15. Birthplace Germany.

16 (a) Informant George W. McCubbin,
(b) Address 4663 Park Heights Ave.,

17 (a) burial (b) Date thereof 4/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lennon,
(b) Address 4611 Park Heights Ave.

APR 30 1945 Huntington Williams, M.D.
(Date rec'd by regis(rar)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH April 27, 1945, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1945 to 4/27/ 1945, and that I last saw her alive on 4/27/ 1945

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to

Due to

Other Conditions Arteriosclerosis with Cholecystitis — 2 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Palazzo M. D.
Address 3326 Frederick Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~3389~~ 68389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 68389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 East 25th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William R. Bishop
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1876 - Oct 28
8. AGE: Years 68 | Months 4 | Days 6 | If less than one day — hr. — min.
9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Retired Vice President
11. Industry or business Fidelity & Deposit Co.
FATHER 12. Name George W Bishop
13. Birthplace Maryland
MOTHER 14. Maiden Name Ellen Parsley.
15. Birthplace Maryland.
16 (a) Informant William R. Bishop, Jr.
(b) Address 3800 Chestnut St., Phila. Pa.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Makemie Mem. Chr.
Location Snow Hill, Md.
18 (a) Funeral director H. W. Meeks and Son
(b) 805 N. Calvert Street
19 (a) APR 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29/45, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 4/29 1945.
and that I last saw h.e alive on 4/28/45.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Uremia	
Due to Arteriosclerotic catarrhal renal disease	
Other Conditions Paroxysmal Ventricular Tachycardia	

(Include pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M.D.
Address Union Memorial H. Date signed 4/29/45

VS 150 Use Motor Hearse

G28390 Jackson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. G28390

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard J. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie Edwards

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1875

8. AGE: Years 69 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Ann Arundle Co. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name James Thomas Edwards

13. Birthplace Md.

MOTHER 14. Maiden Name Rebecca Garrett

15. Birthplace Md.

16 (a) Informant Annie E. Taylor

(b) Address 1040 W. Saratoga St.

17 (a) Burial (b) Date thereof 4/30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Bryant Ley Ave

19 (d) APR 30 1945 Hunting for Holloway M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26- 1945, at 6.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18-1945 to 4-26-1945; and that I last saw h alive on 4-25-1945

Immediate cause of death — Duration

(a) Pneumonia Carcinoma, 4 days
Due to Hypertrophy of Prostate 6 mos.
Due to Hydronephrosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 601 Mathieu Medical Arts Bldg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. 628391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Vincent St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1944

8. AGE: Years | Months: 7 | Days: 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Augustus Johnson

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Ada Jackson

MOTHER 15. Birthplace Md

16 (a) Informant Augustus Johnson

(b) Address 321 S. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location Elroy O. Wilson

18 (a) Funeral director

(b) Address 500 Brantley ave.

APR 30 1945

19 (a) (Date rec'd by registrar) (b) Huntington White Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1945, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1945, to 4/27 1945 and that I last saw h[illegible] alive on 4/27 1945.

Immediate cause of death Cerebral Apoplexia

Due to Hemiplegia

Due to 2

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address Clinic Hosp Date signed 4/27/45

X

G28392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G28392 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Ball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Viola Ball

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1908

8. AGE: Years	Months	Days	If less than one day
37	2	5	hr. min.

9. Birthplace Lancaster Va. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name John Ball
13. Birthplace Va

MOTHER 14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant Viola Ball
(b) Address 910 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1945

(c) Cemetery or crematory
Location Lancaster, Va.

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) APR 30 1945 (b) Registrar

MEDICAL CERTIFICATION 53

20. DATE OF DEATH: April 28, 1945, at 4 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Stab wound of right arm.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 27 1945 at 9 30 P.M.
(b) Where did injury occur? In front of 3137 N. Pulaski Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Stabbed during altercation

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 28 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G28393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

G28393 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Gough St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town XXXXXXXXXXXXXXXBaltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna Czarski

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Walenty Czarski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business At home

FATHER
12. Name Geo. Kline
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Germany

16 (a) Informant Frank Czarski
(b) Address 706 S. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) [illegible] (b) Huntington Williamsburg

APR 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945 at 6 h. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to April 27 1945, and that I last saw h[illegible] alive on April 29 1945.

Immediate cause of death	Duration
Acute Coronary Occlusion	Acute
Due to Coronary Artery Sclerosis	2
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 700 [illegible] Date signed 4/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G28394 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth B. Fortenbaugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1875

8. AGE: Years	Months	Days	If less than one day
69	6	19	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Fortenbaugh
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Raat
15. Birthplace Austria

16 (a) Informant Charles O. Fortenbaugh
(b) Address 1526 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4.30.45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 (a) APR 30 1945 (Date received by registrar) (b) Registrar

VS 180

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1945; at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 4/26 1945, and that I last saw h[illegible] alive on 4/26 1945.

Immediate cause of death	Duration
(a) Coronary Thrombosis	24 hrs
Due to Arteriosclerotic C V disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5213 Roosevelt Ave Date signed 4-27-45

G28395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √123

Registered No. G28395

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 38 Sinia Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE JACOBS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George R.Jacobs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.13-1910

8. AGE: Years	Months	Days	If less than one day
35	3	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Frank C.Brown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth M.Ott
15. Birthplace Balto. Md.

16 (a) Informant George R.Jacobs
(b) Address 2408 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Cem.
Location Taylor Ave.

18 (a) Funeral director John A. Meffer
(b) Address 2304 Jefferson St.

19 APR 30 1945 (Date received by local registrar) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1945, at 12 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1945 to 4/26 1945.
and that I last saw h. alive on 4/26 1945.

Immediate cause of death Cardiac Failure of 24-48 hours — Duration

Due to — Duration over

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman M. D.
Address Sinai Hospital Date signed 4/26/45

X

G28396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28396

XO #66235

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 11 - 4
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 N. Stricker St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Johnson Jones or Jones Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife Cornelius
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1874

8. AGE: Years	Months	Days	If less than one day
70	8	5	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business American Sugar Refinery

FATHER
12. Name Harrison Jones (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Hunner (d)
15. Birthplace ? Not known

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman

19 APR 30 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 27, 1945, at 10:30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22, 1941 to Apr. 27, 1945 and that I last saw him alive on Apr. 27, 1945.

Immediate cause of death Cerebral hemorrhage — Duration 1hr

Due to: Hypertension and Arteriosclerosis

Due to: Uremia

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature [redacted] M.D.
Address [redacted] Date signed [redacted]

VS 150

628397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. 628397

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aurthur Bias

3 (b) If veteran, name war —
3 (c) Social Security Account No. 244-16-5702

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 / 29 / 1890

8. AGE: Years	Months	Days	If less than one day
54	3	29	hr. (1840) min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Bias
13. Birthplace Md

MOTHER
14. Maiden Name Susan Stokes
15. Birthplace Md

16 (a) Informant Rose Bias
(b) Address 1126 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 / 2 / 45 (month) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Md Anne Arundel Co

18 (a) Funeral director George E. Kelso
(b) Address 1303 Pleasant St.

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Huntington Williams II Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1945, to April 28 1945, and that I last saw h— alive on April 28 1945

Immediate cause of death	Duration
Carcinoma head of Pancreas	
Due to Carcinoma head of Pancreas	
Due to	
Other Conditions Cachexia, malnutrition, contributed destruction	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: Carcinoma of Head of Pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Jernigan M. D.
Address University Hospital Date signed 4-29-45
X Jernigan

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G28398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 S. Fremont Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JAMES EDWARD SIMMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-0135

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1903

8. AGE: Years	Months	Days	If less than one day
42	2	19	.....hr. .....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Graham's Storage Warehouse Co.

FATHER
12. Name William Johnson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Eleanor Simms
15. Birthplace Baltimore, Maryland

16 (a) Informant Mary Simms wife
(b) Address 1015 S Fremont Ave

17 (a) Burial (b) Date thereof May 4, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Lebanon
Location Baltimore County

18 (a) Funeral director Joseph G. Brady
(b) Address 4104 Mount Street

APR 30 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th, 1945, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 30 1945

628399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 a

628399 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 Aulds St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Aulds St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter J. Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1890

8. AGE: Years 55 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Parkville Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Matthews
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant Ruby Pride
(b) Address 642 Aulds St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert G. Elmer Sons
(b) Address 1129 W. Baltimore St.

APR 30 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 45 at 7 a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 19 45 to April 29 19 45 and that I last saw h. z. alive on April 28 19 45

Immediate cause of death: Clinical Intestinal Asphixia — Duration: 2 mo

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irene A. Johnson

Address 2329 Jerusalem Date signed April 30 1945

VS 150

G28400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28400 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT St. & RUTLAND AVE
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 E. PRATT St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS GOLDSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Rachel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V-1-45 (month) (day) (year)
(c) Cemetery or crematory Herrera Rung
Location Phila Rd & Bowley Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

R 30 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/1945, at 3.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29/1945, to 9/30 1945, and that I last saw him alive on 9/29/1945

Immediate cause of death: Cardio-Resp. failure — Duration

Due to: Hypostatic Pneumonia

Due to: Coronary Occlusion / Hypostatic Pneumonia

Other Conditions: Cardiac Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harley H. Shriley, M.D.
Address Sinai Hospital Date signed 9/30/45

VS 150

X

G28401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 80 B

G28401 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5017 Harford Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Bonaccorsi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1927

8. AGE:	Years	Months	Days	If less than one day
	17	9	29	hr. min.

9. Birthplace Baltimore (City) - Maryland
(Town, county, and state)

10. Usual Occupation waiter

11. Industry or business

FATHER
12. Name Santi Bonaccorsi (deceased)
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Bonaccorsi (deceased)
15. Birthplace Italy

16 (a) Informant Angeline Bonanno
(b) Address 5017 Harford Rd. Baltimore

17 (a) Burial (b) Date thereof May 1- 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Frank T. Pepe Sons
(b) Address 2818 E. Balto St

19 (a) Date received registrar Huntington Williams M.D.

APR 30 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 27 1945, at 4 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 23 1945 to Apr. 27 1945, and that I last saw h[illegible] alive on Apr. 25 1945

Immediate cause of death	Duration
Respiratory failure	
Due to ? Encephalitis	± 3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp. Date signed 4/27

X

G28402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G28402

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 Woodington Road
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Woodington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Emrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Emrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1863

8. AGE: Years	Months	Days	If less than one day
82	1	26	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired Chief Engineer
11. Industry or business Balto. City Fire Dept.

FATHER
12. Name Frederick Emrich
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Marie Emrich
(b) Address 641 Woodington Road

17 (a) Burial (b) Date thereof May 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Chas. C. Emrick
(b) Address 5701 Rock Spring Rd.

19 APR 30 1945 (Date filed by registrar) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 10.00

20. DATE OF DEATH April 28, 1945, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to April 28, 1945, and that I last saw him alive on April 28 1945.

Immediate cause of death Edema of lungs. — Duration 1 day

Due to Carcinomatosis — 3 mos.

Due to Primary carcinoma of large intestine — 1½ yrs.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 1943

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells M. D.
Address 4100 Edmondson Ave. Date signed 4/30/45

X

628403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

628403 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Pontiac
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5/12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Pontiac Pontiac
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Upton S. Alexander

3 (b) If veteran, name war Spanish-American War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emelia Alexander
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 5 1880
8. AGE: Years 64 | Months 10 | Days 23 | If less than one day hr. min.
9. Birthplace Asheville N C (Town, county, and state)
10. Usual Occupation Laborer Retired
11. Industry or business U. S. Army

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Alexander
15. Birthplace Unknown

16 (a) Informant Mrs Helen Hall
(b) Address 1627 E. Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wilson & Colgan
(b) Address 1214 Druid

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Lucian Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 28 1944 to April 28 1945, and that I last saw h alive on April 27 1945

Immediate cause of death: Carcinoma Rectum

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 6 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F F A Stevens

Address 2918 Harford Rd Date signed M 4 D 30 45

VS 150

X

628404 628404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓1862 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 St. Dunstan Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 St. Dunstan Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Tubman Watts

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sewell S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1906

8. AGE: Years 39 Months 38 Days — If less than one day hr. min. 27

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Eugene Tubman

13. Birthplace Westminster Md.

MOTHER 14. Maiden Name Regina M. Powers

15. Birthplace Washington D.C.

16 (a) Informant Claude W. Wilhide

(b) Address 3926 Canterbury Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)

(c) Cemetery or crematory St. Johns

Location Westminster

18 (a) Funeral director Fulton & Cook Inc

(b) Address 1224 Eutaw Place Baltimore, Md

19 (a) APR 30 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1945, at 1 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 29 1945 4:00 P.M.
(b) Where did injury occur? 105 St Dunstans Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fall downstairs

23. Signature Robert L. Bratton M.D.
Medical Examiner.
Date signed April 30 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

628405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

628405
Registered No.

JO #91652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Frances Campbell

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-12-2814

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	26	hr. min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leon
13. Birthplace Kentucky

MOTHER
14. Maiden Name Elizabeth Bartey
15. Birthplace Kentucky

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 5/3/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Milligan & Ford
(b) Address 124 N. Howard St.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

APR 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1945, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18, 1945 to Apr. 29, 1945 and that I last saw h. in alive on Apr. 29, 1945.

Immediate cause of death Bronchopneumonia

Due to Organic cerebral

Due to Generalized arteriosclerosis

Other Conditions Benign prostatic hypertrophy with chronic urinary infection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

Duration
?
?
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Phillips M. D.
Address Baltimore Md. Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G28406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G28406 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2320 Hilton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Peterson

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas. Peterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 2, 1874.

8. AGE: Years: 71 | Months: 2 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business

FATHER
12. Name: John Wisl
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Cathy Frazier
15. Birthplace: Baltimore Md.

16 (a) Informant: Ford. Feehley
(b) Address: 628 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 1, 1945 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Taylor ave

18 (a) Funeral director: Waldell & Kippel
(b) Address: 312 S. Highland Ave
Huntingtown Williams, Md.

APR 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945 at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1945 to April 28 1945 and that I last saw h[illegible] alive on April 25 1945.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 week
Due to:
Due to:
Other Conditions: Bed sores
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jos. L. Levy M. D.
Address 2322 Eutaw Place Date signed 4/28/45

VS : 4/28/45 Have Spoken to Dr. Zubinski X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G28407 — BALTIMORE CITY HEALTH DEPARTMENT — G28407 Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymond
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. Hundertmark

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles W. Hundertermark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1880

8. AGE: Years	Months	Days	If less than one day
64	6	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Charles H. Yingling
13. Birthplace Md.

MOTHER
14. Maiden Name Dora Fraski
15. Birthplace Germany

16 (a) Informant Mr. Charles W. Hundertmark
(b) Address 1820 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams, M.D. Registrar
(Signature of Registrar)
MAY 1 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945, to April 29 1945; and that I last saw h.e.r. alive on April 29 1945.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard W. Baldwin M. D.
Address West Baltimore General Hosp. Date signed 4/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. In case write the causes of death clearly and legibly.

G28408 ✓ G28408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Milford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE B. PERKINS

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife David R. Perkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1866

8. AGE: Years	Months	Days	If less than one day
78	5	24	hr. min.

9. Birthplace Raleigh, N. C.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John G. Bagwell
13. Birthplace N. C.

MOTHER
14. Maiden Name Not known
15. Birthplace "

16 (a) Informant Mrs. Myrtle Hays
(b) Address 3918 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar APR 30 1945 (b) Huntington Williams, M.D. Registrar

VR 150 MAY 1 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930, to April 28 1945. and that I last saw h er alive on April 27 1945.

Immediate cause of death	Duration
Deformative arthritis	3-4 years
Due to Arteriosclerotic Cardiovascular disease	3 years
Due to	
Other Conditions Right Sided Failure Pulm Edema	36 hours

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex H Weinstock M. D.
Address 4603 K Ht Ave Date signed 4/30/45

X

G28409 ✓ G28409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 N. Milton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOHN M. MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife: Amelia M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Stationary Eng.
11. Industry or business Southern Service

FATHER
12. Name George Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. George A. Miller
(b) Address 308 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) (Date rec'd by registrar) Registrar

MAY 1 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to April 28 1945. and that I last saw him alive on April 27 1945.

Immediate cause of death	Duration
Acute Myocarditis.	2 days
Due to Streptococcus Sore Throat	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott Dingwall M. D.
Address 1613 E. North Ave. Date signed 4-30-45.

G28410 ✓ G28410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES H. ANDERSON

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ida M. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1871

8. AGE: Years	Months	Days	If less than one day
73	10	7	hr. min.

9. Birthplace Washington, Md.
(Town, county, and state)
10. Usual Occupation Retired Carpenter
11. Industry or business

FATHER
12. Name Wm. R. Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Kohlenberg
15. Birthplace Md.

16 (a) Informant Mrs. John Smith
(b) Address 1013 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/43 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 30 1945 (Date rec'd by registrar) (b) [illegible] Registrar

APR 1 1945

VS 150

MEDICAL CERTIFICATION.

20. DATE OF DEATH April 29, 1945, at 1:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945 to April 29 1945, and that I last saw h[illegible] alive on April 27 1945

Immediate cause of death: Congestive heart failure — Duration: 2 days
Due to: Arterio-sclerotic heart disease
Other Conditions: Hypertrophic arthritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1321 Fed. Av. Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

Registered No. 628411

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Eden st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 N. Eden st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie B. Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Fem.

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Brown

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) May 16 1898

8. AGE: Years 46 | Months 11 | Days 13 | If less than one day: hr. min.

9. Birthplace Prince George Co. Md
(Town, county and state)

10. Usual Occupation Beautician

11. Industry or business

FATHER
12. Name Joseph Vaughn
13. Birthplace Va

MOTHER
14. Maiden Name Florence Peoples
15. Birthplace Va

16 (a) Informant Blanch Diggs
(b) Address 1745 E. Oager.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore

18 (a) Funeral director J. B. Inman
(b) Address Annapolis

19 (a) [illegible] received by me from Huntington Williams, M.D.

MAY 1 1945

VS 710

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28- 1945, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28- 1945, to 4-28- 1945, and that I last saw h[illegible] alive on 4-26- 1945.

Immediate cause of death Metastasis
thereof from Ca Rt breast

Due to Carcinoma of Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Refused Hysterectomy
Major findings of operation: Hospital

of autopsy:

Duration
Rt
[illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 611 N. Carrollton Ave Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

628172

AB-93283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 638172

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 217 S. Bentlou St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Hartman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4-1900

8. AGE: Years	Months	Days	If less than one day
45	3	24	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name Charles Hartman

13. Birthplace Md.

MOTHER

14. Maiden Name Alice Foley

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals(Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof May 2 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md.

18 (a) Funeral director Geo. L. Schwab

(b) Address 2101 Frederick Avenue

19 (a) MAY 1 1945 (b) Hunter Stevenson Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28- 19 45, at 6.25P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24- 19 45, to 4- 28 19 45, and that I last saw her alive on 4-28- 19 45.

Immediate cause of death	Duration
Heart failure	days
Due to Pulmonary Tuberculosis	4 years
Due to	
Other Conditions Heart insufficiency	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address Balto. Md. Date signed 4-29-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 8113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 E. Preston Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Brenning

3 (b) If veteran, name war: W

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Joseph Brenning

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 18th 1886

8. AGE: Years: 58 | Months: 10 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business: St. Josephs Hospital

FATHER
12. Name: Thomas McGarity
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary (Unknown)
15. Birthplace: Md.

16 (a) Informant: Mrs Jennie O'Brien
(b) Address: 1214 E. Preston St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof: 5/3/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 5 ^M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-21-45 6:30 A M.
(b) Where did injury occur? Yard of St. Joseph's Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hit in head with bottle

23. Signature: Robert Lee Graham M.D. Medical Examiner.
Date signed: April 30 1945

VS 151

G28114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G28114

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1 West Franklin (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Isabella Cregier Rider

3 (b) If veteran, name war — Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Herbert E. Rider

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1875

8. AGE: Years	Months	Days	If less than one day
70	3	18	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frederick Cregier

13. Birthplace New York

MOTHER 14. Maiden Name Rosa Marschall

15. Birthplace ~~New York~~ Germany

16 (a) Informant Rosemary Rider

(b) Address 1 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto., Md.

18 (a) Funeral director Williams Cook Inc

(b) Address 1217 St Paul St

19 (a) (Date rec'd by Registrar) MAY 1 1945 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 2 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1945 to April 30 1945 and that I last saw h.. alive on April 30 1945

Immediate cause of death Cardiac failure — Duration

Due to Carcinomatosis

Due to Carcinoma of the uterus — 8 mos.

Other Conditions partial int. obstruction

(Include pregnancy within 3 months of death)

Date of operation April 5, 1945

Major findings of operation: gen. carcinomatosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Roy Byron Leeman Jr. M. D.

Address Mercy Hospital Date signed April 30 '45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

G28415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G28415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 Warden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Warden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Schmidt

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23rd 1882

8. AGE: Years 62 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Jonathan Mallalieu
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Tucker
15. Birthplace Balto. Md.

16 (a) Informant John Schmidt
(b) Address 1037 Warden St

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 5/3/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 Filed MAY 1 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th 1945; at 3 16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7- 1944, to Apr 30 1945 and that I last saw her alive on Apr 29 1945.

Immediate cause of death: Carcinoma of Uterus

Due to: with Metastases

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Jan 1944

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown

Address 1663 W. North Ave Date signed 4/30/45

28416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 28416

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 N. Collington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Scott

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John A. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31st 1883

8. AGE: Years 61 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Baier
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Bruder
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs George Brogan
(b) Address 2117 Cliftwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAY 1 1945 (Date rec'd by registrar) (b) Huntington Wills (Registrar) M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th 1945, at 11:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945 to April 29 1945, and that I last saw him alive on April 29 1945

Immediate cause of death Chronic Myocarditis — Duration

Due to Arteriosclerosis Cardio-vascular Renal Disease

Due to

Other Conditions Chronic arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel B Wolfe M. D.
Address 1321 North Ave Date signed 5-3-45

628137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 E

Registered No. 628112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 W 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Joan Linville

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-22-44

8. AGE: Years | Months: 1 mo | Days: 7 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Linville
13. Birthplace North Carolina

MOTHER
14. Maiden Name Sally Jones
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 5/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greensboro
Location N. C.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 MAY 1 1945 (b) Huntington Williams, M.D.
(Date rec'd by local reg.) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1945 to April 29 1945, and that I last saw her alive on April 29 1945.

Immediate cause of death: Cardiac failure — Duration

Due to: Congenital

Due to: Lobar disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Kaye M.D.

Address 1 W Mt Royal Ave Date signed 5/1/45

VS 150

G28418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28418

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WEST BALTO. GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 N. APPLETON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BERMAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: DA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1886
8. AGE: Years [redacted] 59 Months Days If less than one day hr. min.
9. Birthplace: RUSSIA (Town, county, and state)
10. Usual Occupation: PAINTER
11. Industry or business

FATHER
12. Name: BENJ.
13. Birthplace: RUSSIA

MOTHER
14. Maiden Name: ANN SARAH
15. Birthplace: RUSSIA

16 (a) Informant: WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-1-45 (month) (day) (year)
(c) Cemetery or crematory: ROSEDALE
Location: PHIL RD + HAMILTON AVE
18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E. Baltimore St
19 MAY 1 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 30, 1945, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an INSPECTION (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 4-30-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G28419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G28419 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alma M Despeaux

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3-1901

8. AGE: Years 43 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Domestic

FATHER
12. Name Adam Despeaux
13. Birthplace Baltimore

MOTHER
14. Maiden Name Laura Nores
15. Birthplace Baltimore

16 (a) Informant Louis N. Pral
(b) Address 2207 Mulliken

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 2/45 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cem
Location Balto Md

18 (a) Funeral director Wilbur Funeral Home
(b) Address 2008 Orleans St

19 (a) MAY 1 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945 to April 29 1945. and that I last saw h[illegible] alive on April 29 1945.

Immediate cause of death: Acute Cardio-Respiratory failure
Due to Acute myocarditis + endocarditis
Due to
Other Conditions Chr nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
acute
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos J Despeaux M.D.
Address 700 N Patterson Park Ave Date signed 4/30/45

G28420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 80a

G28420 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Windsor
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Tyler Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LANSING HEADLEY Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Bertie Headley
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 10, 1912

8. AGE: Years 32 33 | Months 11 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business Sparrows Point

FATHER
12. Name Lansing Headley Sr.
13. Birthplace West Virginia

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-1945 (month) (day) (year)
(c) Cemetery or crematory Trinity City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 S Arlington Ave

19 MAY 1 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945 at 12 N M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 4/28 1945 and that I last saw him alive on 4/28 1945

Immediate cause of death Cardio Resp. Failure — Duration

Due to Brain Abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Right frontal brain abscess

Date of autopsy: X

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. K. Speakes M.D.
Address Mercy Hosp. Date signed 4/28/45

X

VS 150

G28421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28421

PLEASE WRITE PLAINLY. IT ... should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 E. 22nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 E. 22nd St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George L. McCrone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Ida B. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1887

8. AGE: Years	Months	Days	If less than one day
57	4	14	...hr. ...min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business B. & O. R. R.

FATHER 12. Name Richard McCrone

13. Birthplace Md.

MOTHER 14. Maiden Name Sybilla McComas

15. Birthplace Pa.

16 (a) Informant Mrs. Ida B. McCrone

(b) Address 331 E. 22nd St. Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Springfield Cemetery

Location Lyketsville, Md.

18 (a) Funeral director C. Harry Wiles

(b) Address Lyketsville, Md.

19 MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1942 to Apr. 1945, and that I last saw him alive on April 28 1945

Immediate cause of death	Duration
Hypertensive Arteriosclerotic Heart Disease with Congestive Failure	Yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert W. Garcia

Address 1014 St. Paul St. Date signed 4/30/45

6-28422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6-28422

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 Wash Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Wash Blvd
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William J Butler

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-9633

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Grace H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/29/188[illegible]

8. AGE: Years	Months	Days	If less than one day
57	3	1	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Pt Engineer
11. Industry or business

FATHER
12. Name Geo Butler
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia
15. Birthplace Md

16 (a) Informant Grace H Butler
(b) Address 2425 Wash Blvd

17 (a) Burial (b) Date thereof 5/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Medos Ridge
Location Wash Blvd

18 (a) Funeral director Edward Taylor
(b) Address 359 Wash Blvd

19 (a) MAY 1 1945 (b) Huntington Williams Md
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 4/30 1945 and that I last saw him alive on 4/21 1945

Immediate cause of death Coronary thrombosis — Duration 5 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar H. Miller M. D.
Address 2029 Wood. Blvd Date signed 4/30/45

Edgar H. Miller X

G28423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28423 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 W Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Laura A. Stocksdale

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1869

8. AGE: Years	Months	Days	If less than one day
75	11	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Silas H. Stocksdale
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Jane Heiser (HEISER)
15. Birthplace Maryland

16 (a) Informant Mrs. F. J. Stocksdale
(b) Address 1913 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-1945 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Westminster, Maryland

18 (a) Funeral director Dugan Funeral Home
(b) Address 3631 Falls Road

MAY 1 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1945 to April 28 1945 and that I last saw h.[illegible] alive on April 28 1945.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Acidosis

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Morris M.D. April 29 1945
M. D.
Address Date signed

G28424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 Q

Registered No. G28424

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town 1327 W. 42nd St. Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 W. 42nd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nina A. Parran

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wm Nathaniel Parran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/60

8. AGE: Years	Months	Days	If less than one day
84	7	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jack Eddins
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Lee
15. Birthplace Virginia

16 (a) Informant Mrs. Helen McElvany
(b) Address 1327 W. 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3621 Falls Road

MAY 1 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1945, at 9:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1945 to 4-30 1945, and that I last saw her alive on 4-30 1945.

Immediate cause of death	Duration
Cardio-resp. failure	
Due to Broncho-pneumonia, bilat.	
Due to	
Other Conditions Fracture, neck of left femur (Include pregnancy within 3 months of death)	

Date of operation 4-23-45
Major findings of operation: fracture neck left femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/8
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4-19-45 at 10 P.M.
(c) Where did injury occur? Baltimore (City or town) — Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped + fell to floor

23. Signature Paul E. Gore M. D.
Address Union Memorial Hospital Date signed 4-30-45

Approved — Howard J. Madden, M.D.

G28425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

G28425 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Woodhome Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Woodhome Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick G. Grundman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria A. Grundman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/7/77

8. AGE: Years	Months	Days	If less than one day
68	0	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Leather Goods

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Paul E. Grundman
(b) Address White Hall Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 2 45 (month) (day) (year)
(c) Cemetery or crematory St. Johns Luth.
Location Balto. Co. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 3401 Belair Rd.

19 (c) MAY 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th 1945, at 2:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1944 to Apr 30 1945 and that I last saw h[illegible] alive on 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration: Apr. 30/45

Due to

Due to

Other Conditions: Chronic Myocarditis — Duration: 7 Years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Morris B. Green M.D.
Address 3009 Evergreen Ave Date signed 4/30/45
Baltimore 14 Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

628426 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 658 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 658 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — - 1871

8. AGE: Years 73 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Clara Robinson

(b) Address 704 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem. Mt. Calvary Cem.

Location A.A. Co. Md.

18 (a) Funeral director Williams & Pickard

(b) Address 914 Penna. Ave.

19. MAY 1 1945 (Date rec'd by Registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1945 at 9 40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-22-45

VS 151

G28427 ✓ G28427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Upton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Upton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J Thorne

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-1886

8. AGE: Years	Months	Days	If less than one day
59	—	18	hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Perry Barnes
13. Birthplace N.C

MOTHER
14. Maiden Name Louisa ?
15. Birthplace ?

16 (a) Informant Lavinia F Coleman
(b) Address 7 D Johnson ave

17 (a) Burial (b) Date thereof 5 / 1 / 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna Ave

19 MAY 1 1945 Huntington Williams Mgr
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1945, to April 28 1945, and that I last saw h[illegible] alive on April 28 1945

Immediate cause of death Cerebral Hemorrhage — Duration April 28

Due to Hypertension

Due to Cerebral Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 803 N Fremont Ave Date signed May 1

628428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 628428

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 N. Patterson Pk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1435 N. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H Lynch

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ina Lynch

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 6-6-1897

8. AGE: Years 47 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Salem West Va. (Town, county, and state)

10. Usual Occupation Homeless Cafe

11. Industry or business Bartender

FATHER 12. Name C. A. Lynch

13. Birthplace Harrison Co. West Va

MOTHER 14. Maiden Name Harriet Wheteman

15. Birthplace Harrison Co. West Va

16 (a) Informant Ina Lynch

(b) Address 1435 N. Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-45 (month) (day) (year)

(c) Cemetery or crematory Bolton Hill Cem

Location Frederick Road

18 (a) Funeral director John E Milby Inc

(b) Address 2435 E Oliver St

19 (a) MAY 1945 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-1945, at 8.11 M

21. I certify that death occurred on the date above stated that I attended deceased from Feb 1945 to April 29 1945, and that I last saw him alive on April 29 1945.

Immediate cause of death: CARDIAC ASTHMA — Duration: 3 mo.

Due to CHR MYOCARDITIS — 3 mo.

HYPOSTASIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. F. Kavanaugh M.D.

Address 3326 McElderry St Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G28429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G28429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Arlington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Schick

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Rosina Schick
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 1857

8. AGE: Years	Months	Days	If less than one day
88	0	12	....hr. ....min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Leo J. Schick (son)
(b) Address 2619 Arlington Ave

17 (a) Burial (b) Date thereof 5 3 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Miller Inc.
(b) Address 2436 E. Oliver St.

MAY 1 1945 Huntington Hilliard
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to April 30 1945 and that I last saw him alive on Apr 30 1945

Immediate cause of death: Bronchopneumonia — Duration: 3d.
Marasmus senilis — 4d.
Due to Arterio Sclerosis — 9d.
Due to Chronic Interstitial Nephritis — 9d.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ira A Stevens
Address 2878 Hanford Rd Date signed 4 30 1945

X

G28430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G28430

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~829 Williams St.~~
(c) Hospital or institution: So. Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Williams St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1898

8. AGE: Years	Months	Days	If less than one day
46	7	15	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Pipefitter

11. Industry or business

FATHER
12. Name A. B. White
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Travers
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Emma White
(b) Address 743 Guilford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Henry Inc Ed Henry
(b) Address 745 Light St.

MAY 1 1945 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from on 4-24-45 19
and that I last saw him alive on 4/22/45

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address So. Balto Gen Hosp. Date signed 4/30/45

Approved by John Davis M.D. Resident Physician So. Balto Gen Hosp.

G28431

Dr. Geo. L. Zimmerman
9858 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V93D

Registered No. G28431

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Halcyon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Halcyon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Reed Hoerder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Charles Hoerder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Walch
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. C. W. S. Hoerder
(b) Address 2706 Halcyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24-44 1945 to 4-29 1945
and that I last saw her alive on 4-29 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Chronic Myocarditis	1 yr
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Zimmerman M. D.
Address 9858 Harford Rd Date signed 4/30/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 628432

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Baltimore~~ Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Wycliffe Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Svoboda (SVOBODA)

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Grace E. Svoboda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1892

8. AGE: Years 52 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Chamberlain Insulating

11. Industry or business: Co.

FATHER
12. Name: Louis Svoboda
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs. Grace E. Svoboda
(b) Address: 2618 Wycliffe Road

17 (a) Bruial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory: Prospect Hill
Location: Towson, Balto. Co. Md.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road

19 MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION 4-30-45

20. DATE OF DEATH 5:00 Am 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1945, to 4-30 1945 and that I last saw h.l. alive on 4-30 1945

Immediate cause of death: Cancer stomach — Duration: 6 mos.

Due to

Due to

Other Conditions: Intestinal obstruction
(Include pregnancy within 3 months of death)

Date of operation 4-8-45

Major findings of operation: Cancer

of autopsy: Cancer stomach + metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers M. D.

Address 7 Hamilton Square Hosp Date signed 4-30-45

G28433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28433 / 312

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4315 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Harford Road -14- (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick H. Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1880

8. AGE: Years	Months	Days	If less than one day
64	6	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Machinist B & O RR

FATHER
12. Name Henry Wagner
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Hartman
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Wagner
(b) Address 4315 Harford Road -14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 1 1945 Washington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29- 1945, at 4 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4- 1938 to 4-29- 1945, and that I last saw him alive on 4-28- 1945.

Immediate cause of death: Cardio-vascular renal disease — Duration: 7 years
Due to Generalized arteriosclerosis — 7 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed 4-30-45

VS 150

628134

J1 - 93348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 628134

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Boley's Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine ~~Fischer~~ VICTOR Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Helen MARIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1896

8. AGE: Years	Months	Days	If less than one day
49 ~~55~~ ?	3	?	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Baltimore City Police
11. Industry or business

FATHER
12. Name John C. Fischer
13. Birthplace ? Md.

MOTHER
14. Maiden Name Mary M. Burkhauser
15. Birthplace ? Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore

18 (a) Funeral director Leonard J. Rucke
(b) Address 535 Hartford Rd.

19 (a) MAY 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945 at 8:55P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1945, to April 28 1945, and that I last saw h im alive on April 28 1945.

Immediate cause of death Coronary occlusion — Duration 30 min. ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Perry M.D.
Address City Hosp. Date signed 5/2/45

Approved Hugh A. McCauley To be approved by Medical Examiner Robert Lee Sutton M.D.

628435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

628435

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County J
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 N. Chester St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. JOSEFA SVEHLA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife FRANK SVEHLA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Vondracek
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Joseph Svehla
(b) Address 1207 N. Chester

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt. Md.

18 (a) Funeral director Frank Evork & Son
(b) Address 900 N. Chester St

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1945, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1945 to 4/29 1945, and that I last saw her alive on 4/29 1945

Immediate cause of death PULMONARY TUBERCULOSIS — Duration

Due to

Due to

Other Conditions COMPRESSION FRACT. 1ST LUMB. VERT., DIABETES
(Include pregnancy within 3 months of death)

Date of operation 3/29/45 BODY CAST

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence March 25, 1945 M
(c) Where did injury occur? 1207 N. Chester St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? NO
(e) Means of injury Fell down the stairs

23. Signature Paul D. Herold
Address Md. Gen. Hosp. Date signed 4/29/45 M. D.

approved:— Howard J. Mruzek, M.D.

628436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 628436

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 E Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 E. Chester St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Huether

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minnie Huether
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov. 26 1872

8. AGE: Years 72 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Upholsterer
11. Industry or business

FATHER
12. Name Louis Huether
13. Birthplace Germany

MOTHER
14. Maiden Name Gottschoon
15. Birthplace " "

16 (a) Informant Minnie Huether
(b) Address 811 E. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto Md

18 (a) Funeral director Frank Groetzinger
(b) Address 900 E. Chester St

19 (a) MAY 1 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to April 29 1945, and that I last saw h alive on 19

Immediate cause of death Coronary Occlusion — Duration 4/26/45

Due to Acute Myocarditis — 5/1/44

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Rybaczek M. D.
Address 801 E Lanvale St Date signed 5/1/45

X

628437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. 628437

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 Ilam St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 Ilam St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Singer or Smigle Caldwell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1895

8. AGE: Years	Months	Days	If less than one day
50	-	21	hr. min.

9. Birthplace Woodard, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Singer or Smigle Caldwell.
13. Birthplace Woodard, S.C.

MOTHER
14. Maiden Name Rosie ?
15. Birthplace S.C.

16 (a) Informant Florence Caldwell.
(b) Address 631 Ilam St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 28 1945, at 6.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 27 1945 to Apr. 28 1945, and that I last saw him alive on Apr. 28 1945.

Immediate cause of death	Duration
Massive Hemorrhage from Gastro-intestinal Tract	2 day
Due to Gastric or duodenal ulcer	?
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Haines M.D.
Address 665 W. Barre St. Date signed 4-30-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registration No. 6438

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1879

8. AGE: Years	Months	Days	If less than one day
65	11	20	hr. min.

9. Birthplace Charles County Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Godfrd.
13. Birthplace Pumonkey Md.

MOTHER
14. Maiden Name Maria Godfrd.
15. Birthplace Pumonkey Md.

16 (a) Informant Mrs. Novella Jackson.
(b) Address 114 N. Schroeder St.

17 (a) Burial (b) Date thereof 5-3-'45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pumphrey
Location Charles County Md.

18 (a) Funeral director Mrs. Hatie R. Willson
(b) Address 322 N. Schroeder St.

19 (a) 1945 (b) Arlington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1945 to 4-27 1945 and that I last saw h.er alive on 4-27 1945.

Immediate cause of death	Duration
Acute dilatation of stomach	
Due to Acute Obstruction Intestines	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation 4-27

Major findings of operation: Acute obstruction Epiploic Hernia

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address Univ. Hosp. Date signed 4-27

VS 150

G28439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G28439 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Ailsa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 Ailsa Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elizabeth Raudenbush

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1860

8. AGE: Years	Months	Days	If less than one day
84	7	17	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John A. Walter
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Shoemaker
15. Birthplace Pennsylvania

16 (a) Informant Mr. W. S. Raudenbush
(b) Address 3519 Ailsa Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Lebanon R Pa
18 (a) Funeral director William Cook, Incl
(b) Address 1217 St. Paul Street
19 (a) MAY 1 1945 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 30 1945 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1942 to 4-30 1945 and that I last saw h alive on 4-9 1945.

Immediate cause of death: Acute Myocardial Failure — Duration: 1 day
Due to: Chronic Myocarditis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 4-30-45

G28440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

G28440 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland Ave.
(c) Hospital or institution: West Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARGARET A JOHNSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31 1876

8. AGE: Years 69 | Months 2 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thos. Gillin

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Concannon

15. Birthplace England

16 (a) Informant Mrs Annie P. Gillin

(b) Address 2621 Wilkens Ave

17 (a) Burial (b) Date thereof 5-3-45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic Cem

Location Baltimore Md

18 (a) Funeral director George A Starling

(b) Address Fulton Ave Fayette

19 (a) 1945 (b) Huntington Williams M.D. (Date) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1945 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1945 to 4/30 1945, and that I last saw h. alive on 4/30 1945.

Immediate cause of death Intestinal Obstruction

Due to Mesenteric embolism

Due to Arteriosclerotic gangrene and thrombosis in aorta.

Other Conditions Breast lump - possibly malignant

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Mesenteric embolism.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Felsenfeld

Address West Balt. Gen Hosp Date signed 4/30/45 D.

VS 180

X

G28441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42B

G28441 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B. Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife late Clara E Owens

6 (c) If alive, give age 186~~4~~

7. Birth date of deceased (mo., day, yr.) Aug 22 1865

8. AGE: Years 80 Months 8 Days 7 If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Painter

FATHER
12. Name Samuel B. Wells
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Ann Blincoe
15. Birthplace Va.

16 (a) Informant Mrs David Morris
(b) Address 3320 Hayward Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5.2.45 (month) (day) (year)
(c) Cemetery or crematory Dry Hill
Location Laurel Md.

18 (a) Funeral director Harry A Witzke
(b) Address 4101 Edmondson Ave

19 (a) MAY 1 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to April 29 1945 and that I last saw him alive on April 29 1945.

Immediate cause of death Arterio-Sclerosis — Duration

Due to Chronic Mitral Endocarditis — Duration

Due to Senility — Duration 10 yrs +

Other Conditions of Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. B. Burns M. D.
Address 7201 York Rd Date signed 4-30-45
Balto 12, Md

(OVER)

628142 Inter Keating

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

628142 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts
(c) Hospital or institution: Bon Secours.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 W Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Keating

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-4715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1909

8. AGE: Years	Months	Days	If less than one day
36	-	29	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business Petrol Oil Co

FATHER
12. Name Timothy D. Keating
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ellen Angland
15. Birthplace Ireland

16 (a) Informant My Timothy Keating
(b) Address 2121 W Baltimore St.

17 (a) Burial (b) Date thereof 5.3.45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 3500 Old Frederick Rd

18 (a) Funeral director Harry A Witzke
(b) Address 410 Edmondson Ave

MAY 1 1945 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1945, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1945 to 4-30 1945 and that I last saw her alive on 4-30 1945

	Duration
Immediate cause of death Pulmonary Tuberculosis	3 yrs?
Due to	
Due to	
Other Conditions Generalized Peritonitis	1 mo.

(Include pregnancy within 3 months of death)
Date of operation 2-23-45
Major findings of operation: Cholecystitis Regional Ileitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 4-30-45

X

62843 X

BALTIMORE CITY HEALTH DEPARTMENT X 131B 62843 Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 62d
(e) Length of stay in Baltimore (yrs., mos., or days) 62 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott city
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs. Jane S. Paull

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Glenn H. Paull
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1902

8. AGE: Years	Months	Days	If less than one day
42	5	13	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Jacob Shambaugh
13. Birthplace Ohio

MOTHER
14. Maiden Name Norah Stuckey
15. Birthplace Virginia

16 (a) Informant Glenn Paull
(b) Address Route 1, Ellicott City Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-2-45 (month) (day) (year)
(c) Cemetery or crematory Hollywood
Location Richmond Va.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1945, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1945 to 4-30 1945, and that I last saw her alive on 4-30 1945.

Immediate cause of death Uremia — Duration 2 mos

Due to chronic glomerulo-nephritis — yrs

Due to — yrs

Other Conditions hypertension cardiovascular disease — 2 yrs
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Marvin W. Davis M. D.
Address Church Home Date signed 4-30-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAY 1945

G28444 / 34992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G28444 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Lambrose, Ct. (If rural give location)
(e) Citizen of foreign country? Fremont St (Yes or No)
If yes, name country

3 (a) FULL NAME Charles (Penn) Pew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-90

8. AGE: Years 54 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation trashman

11. Industry or business

FATHER
12. Name Charles Penn
13. Birthplace Del.

MOTHER
14. Maiden Name Evalina ?
15. Birthplace Del.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. A. Stuckert
(b) Address 1631 Druid Hill Ave.

19 (a) Rec'd by registrar (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 7 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1945 to 4-28 1945 and that I last saw him alive on 4-28 1945.

Immediate cause of death: Respiratory failure due to obstruction
Due to: Pneumococcal pleuropitis
Other conditions: Lobar pneumonia Rt. Lung due to pneumococcus Type 12
Major findings of operation:
Date of operation:
Was autopsy?

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Dorsey
Address Johns Hopkins Hospital 5/1/45

810

G28445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. G28445

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 East st
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 East st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Bonomo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Providenza Bonomo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1876

8. AGE: Years	Months	Days	If less than one day
69	3	3	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Retired Fruit
11. Industry or business

FATHER
12. Name Salvatore Bonomo
13. Birthplace Italy

MOTHER
14. Maiden Name Salvatora Glorioso
15. Birthplace Italy

16 (a) Informant Providenza Bonomo
(b) Address 419 East St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St

19 (a) MAY 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944, to 4/29 1945, and that I last saw h. m alive on 4/29 1945.

Immediate cause of death	Duration
Coronary infarction	
Due to Coronary Sclerosis	
Due to Myocardial weakness,	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein
Address 733 Aisquith St Date signed M. 5 D. 1/45

X

VS 150

628446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. 628446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5801 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornell Jordan

3 (b) If veteran, name war —

3 (c) Social Security Account No. 248-40-0471

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edith L. Jordan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/1909

8. AGE: Years	Months	Days	If less than one day
35	5	16	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Traffic Clerk

11. Industry or business Civil Service

FATHER
12. Name Wm J. Jordan
13. Birthplace South Carolina

MOTHER
14. Maiden Name Eliz. Watson
15. Birthplace South Carolina

16 (a) Informant James D. Jordan
(b) Address 5801 Belair Rd.

17 (a) Burial (b) Date thereof 5/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Conway S. C.
Location Conway S. C.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 MAY 1 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30- 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subarachnoid Hemorrhage

Due to Compound Fracture - Tibia & fibula.

Other Conditions Lacerations, bruises & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/1
(a) Date of injury 4-29- at 9:20 P.M.
(b) Where did injury occur? Belair Rd & Gorsuch Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 5-4-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G28447
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Hanover R#1
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herly Berwager
3 (b) If veteran, name war
3 (c) Social Security Account No. 176-05-1752

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Berwager
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 10-24-09.

8. AGE: Years	Months	Days	If less than one day
35	6	7	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Demetti Berwager.
13. Birthplace Md.

MOTHER
14. Maiden Name Lena Doulbert
15. Birthplace Md.

16 (a) Informant Mrs Florence Berwager.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof May 3 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rest Haven.
Location Hanover Pa.
18 (a) Funeral director W. A. Feaser
(b) Hanover Pa.
19 (a) MAY 1 1945 Waiting for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1945, at 11 20 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1945 to 5-1 1945, and that I last saw h[illegible] alive on 5-1 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Myocardiopathy Tuberculosis, chronic	
Due to Acute stage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J. Dieffenbach
Address Johns Hopkins Hospital Date signed May 1 1945

VS 150

G28148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

G28148 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos. or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. —
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Jack Joseph Crehan.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 31, 1920

8. AGE: Years	Months	Days	If less than one day
19	8	1	hr. — min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Maritime Service
11. Industry or business —

FATHER
12. Name Eugene L. Crehan
13. Birthplace Md. —

MOTHER
14. Maiden Name Agnes Stittel.
15. Birthplace Md —

16 (a) Informant Eugene L. Crehan
(b) Address 202 N. Monastery Ave

17 (a) Burial (b) Date thereof 5-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George H. Schwab
(b) Address 2101 Frederick Avenue

19 (a) 5-1-1945 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1945, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1945, to 5-1 1945 and that I last saw him alive on 5-1 1945.

Immediate cause of death	Duration
Medullary compression.	
Due to Brain abscess.	
Due to Chronic otitis media.	
Other Conditions Cystitis.	

(Include pregnancy within 3 months of death)
Date of operation 4-2-45.
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature E. L. Crehan M.D.
M. D.
Address Univ. Hosp. Date signed 5-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G28449 Registered No. (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Eileen Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1866

8. AGE: Years	Months	Days	If less than one day
76 70	9	5	hr. min.

9. Birthplace Glasgow, Scotland (Town, county, and state)
10. Usual Occupation Stone Mason
11. Industry or business Retired

FATHER
12. Name Daniel Murphy
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace Scotland

16 (a) Informant Eileen Murphy
(b) Address 1806 Dover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) MAY 1 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1945, at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 5/1 1945, and that I last saw h[illegible] alive on 5/1 1945.

Immediate cause of death Chronic Myocardial Degeneration — Duration 1 yr.
Due to Arteriosclerotic C.V Disease — 2 yrs.
Due to — 4 yrs.
Other Conditions Pulmonary Thrombosis Chronic Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Gabrielle [illegible]
Address 5/1/45 Date signed

93D

Ada Thornburg Auld

628450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131

Registered No. 628450

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 Park ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Park ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ada Thornburg Auld

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John S. Auld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8. 1867

8. AGE: Years 78 | Months 3 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business At Home

FATHER
12. Name Varden Parquette.
13. Birthplace Va

MOTHER
14. Maiden Name Sidonia Haney
15. Birthplace Va

16 (a) Informant John S. Auld
(b) Address 608 Park ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAY 2 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at 4 30P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 1 1945, and that I last saw her alive on May 1 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 3hr

Due to Arteriosclerosis — 2yr

Due to Hypertension — 3yr

Other Conditions No Autopsy Held

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P A Stevens M. D.
Address 278 Hanford Date signed 5-1-45

VS 130

628451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 A

Registered No. 628451

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2532 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Buchholz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1st 1863

8. AGE: Years 61 | Months 8 | Days 28 | If less than one day hr. min. 18[illegible]

9. Birthplace Emmitsburg Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name John Zumbable
13. Birthplace Md.

MOTHER
14. Maiden Name Annie (McKeown)
15. Birthplace Md.

16 (a) Informant Mrs John Cashman
(b) Address 2532 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAY 2 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1945 to Apr 29 1945, and that I last saw [illegible] alive on Apr 28 1945.

Immediate cause of death: Uraemic Coma — Duration: 3 days

Due to: Thrombosis Left Internal Carotid Artery & Coronary — 18 Years

Due to: Cerebral Hemorrhage with R. Hemiplegia — 11 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Geraghty

Address 10 E. Biddle St Date signed Apr 30/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28432 ✓ G28432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1639

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days) 6'

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine M. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Sheridan F. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1902

8. AGE: Years	Months	Days	If less than one day
42	11	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Dee
13. Birthplace Ireland

MOTHER
14. Maiden Name Ella Enright
15. Birthplace Ireland

16 (a) Informant Sheridan F. Smith
(b) Address 2101 Orleans St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) MAY 2 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sodium Fluoride Poisoning

Due to

Other Conditions Psychoneurosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 30 1945 10 A M.
(b) Where did injury occur? 2101 Orleans St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Swallowed Roach Powder

23. Signature Robert Lee Gratton M.D. Medical Examiner.
Date signed April 30 1945

X

G28453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163a

Registered No. G28453

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel MAE Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband or wife James N. Conner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12th 1908

8. AGE: Years 37 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Addison Twigg
13. Birthplace Flintstone Md.

MOTHER
14. Maiden Name Ada (Unknown)
15. Birthplace "

16 (a) Informant James N. Conner
(b) Address 1134 Homewood Ave

17 (a) Burial (b) Date thereof 5/3/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAY 2 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 11 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sodium Fluoride Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 30 1945 at 10 20 P.M.
(b) Where did injury occur? 1134 Homewood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? ~~Yes~~
(d) Means of injury Swallowed Rat Poison

23. Signature Robert L. Gruber M.D.
Medical Examiner.
Date signed May 1 1945

G28454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 105

G28454 — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 27 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Maisel Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Samuel Wade

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1943

8. AGE: Years	Months	Days	If less than one day
2	3	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Michael Wade
13. Birthplace Tennessee

MOTHER
14. Maiden Name Mary Stant
15. Birthplace Tennessee

16 (a) Informant Mrs. Charles Faulkner
(b) Address 2407 Maisel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director John F. Denny, Inc.
(b) Address 415 Light St.

19 (a) MAY 2 1945 (Date received by registrar) Huntington Hill (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/45, at 12:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1945, to 5/1 1945, and that I last saw h/M alive on 5/1 1945.

	Duration
Immediate cause of death Cardiac failure	
Due to Croup	1 day
Due to etiology undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address Sydenham Hosp Date signed 5/1/45

628455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 628455

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 N. Wolfe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N Wolfe St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Adelman Harris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col	mdow

6 (b) Name of husband or wife Harris (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Yorktown va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Samuel Carter
13. Birthplace York town, Va

MOTHER
14. Maiden Name Lucy —
15. Birthplace va

16 (a) Informant Thelma Taylor
(b) Address 1224 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Ave A. & Gilmor

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

MAY 2 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945, at 5 20 D M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 23 1945 to Apr 28 1945 and that I last saw h alive on Apr 28 1945

Immediate cause of death Mitral Insufficiency — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Pashel M. D.
Address 962 E Monument Date signed 4-30-45

628456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

628456 Registered No.

JO #93272

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Stirling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age 1887 years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1884

8. AGE:	Years	Months	Days	If less than one day
	60	-7-	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Junk Man
11. Industry or business

FATHER
12. Name Thomas (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Robt. E. Williams
18 (a) Funeral director
(b) Address 1515 McElderry
19 (a) (Date rec'd by registrar) (b) Huntington Wills, Registrar

MAY 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1945, at 2:55A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24, 1945, to April 26, 1945, and that I last saw h. im alive on April 25, 1945.

Immediate cause of death: Pulmonary tuberculosis — Duration: ?
Due to
Due to
Other Conditions Emaciation
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address Balto. Md. Date signed 4/27/45 M. D.

VS 190

628457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 2D

Registered No. 628457

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S.Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S.Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter T.Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1247

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francis A.Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5- 1890

8. AGE: Years 54 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Gas & Electric Co

FATHER
12. Name Thomas Mitchell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Greisinger
15. Birthplace Balto. Md.

16 (a) Informant Francis A.Mitchell
(b) Address 620 S.Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Rd.

18 (a) Funeral director John L. Miller
(b) Address 2324 Jefferson St.

19 (a) 1945 Date filed by Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945, at 7.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4/9 1945 to 4/28 1945 and that I last saw h[illegible] alive on 4/27 1945.

Immediate cause of death Carcinoma Ab. Lung
Due to Metastasis Brain
Due to Left Lung
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas L. Newbrand M. D.
Address 1476 E. Eutaw Date signed 4/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 628458

1B-93191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7- 1888

8. AGE: Years 56 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Kane (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Thomas (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Rec
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto md

18 (a) Funeral director William A Jackson
(b) Address 916 Penn ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29- 1945, at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1945, to 4-29 1945 and that I last saw h im alive on 4-29 1945.

Immediate cause of death	Duration
Due to Pulmonary tuberculosis (2)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Balto. Md Date signed 5-1-45

VS 199

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

Registered No. 628459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Mura Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town 2702 Mura (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Marshall Sprock III

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/45

8. AGE: Years | Months: 2 3 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: John Marshall Sprock Jr.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Emma Zink
15. Birthplace: Baltimore, Md.

16 (a) Informant: John Marshall Sprock, Sr.
(b) Address: 607 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/2/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto. Md.

18 (a) Funeral director: C. E. Schimunek
(b) Address: 2601 E. Madison, Street

MAY 2 1945 (Date rec'd by Registrar) Huntington Williams, M.D. (By) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1945, at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: SUFFOCATION
Conditions
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-30-45 at 8:15 P. M.
(b) Where did injury occur? 2702 Mura St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Bedclothes

23. Signature: John R. Weiss M.D. Medical Examiner.
Date signed 5/1/45

VS 151

G28460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28460

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 X Hollins Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 X Hollins St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME STONEWALL JACKSON HAMMER JUNIOR

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-4204

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1885

8. AGE: Years	Months	Days	If less than one day
59	11	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business City of Balto Highway Dept

FATHER
12. Name Stonewall J Hammer Sr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary V. Tingley
15. Birthplace Balto. Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 5-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Hollins St

MAY 2 1945 Washington Hillsboro MD
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30/45 19 , at 9p M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic Cardio Vascular disease

Due to

Other Conditions Pulmonary Osteoarthropathy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 5/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~6~~ 8461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480

Registered No. 8461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 N. Bentalou
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N. Bentalou
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Mae Vause

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Flynn Vause
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1893

8. AGE: Years	Months	Days	If less than one day
52	2	15	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Bailey
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Burris
15. Birthplace Unknown

16 (a) Informant M. Flynn Vause
(b) Address

17 (a) Removal (b) Date thereof 5/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bellview, Florida
Location Florida

18 (a) Funeral director Wm J. Jefferson & Co
(b) Address Balto. Md.

MAY 2 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1945, at M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma lung
Carcinoma cervix

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D.
Medical Examiner.
Date signed 5/2/45

VS 151

628462

BALTIMORE CITY HEALTH DEPARTMENT

CWK 93374

CERTIFICATE OF DEATH

1862

Registered No. 628462

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Hrs. 30 min.

(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 812 Gorsuch Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Giblin

3 (b) If veteran, name war: None

3 (c) Social Security Account No. No

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Patrick J. Giblin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1863

8. AGE: Years 81 ? Months 11 Days 20 If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Dennis Giblin

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary Earley

15. Birthplace Ireland

16 (a) Informant Records, Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin Son

(b) Address 9242 Reisterstown Rd.

19 (a) MAY 2 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to April 30 1945 and that I last saw h[illegible] alive on April 30 1945

	Duration
Immediate cause of death: Pneumonia, extensive	7
Due to: Chronic invalidism	40 yrs.
Due to:	
Other Conditions: fractured sh. tibia & femur (Include pregnancy within 3 months of death)	2 days

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident 9/5

(b) Date of occurrence 4-29-45 at M

(c) Where did injury occur? home
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)

(e) Means of injury fell out of bed

23. Signature R. Cunningham M. D.

Address Balto City Hosp. Date signed 5-1-45

To be approved by Medical Examiner

Howard J. Cuddihy M.D. per Robert Lee Sutton M.D.

VS 100

628463 ✓ 628463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital Sinaea
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 15
(e) Length of stay in Baltimore (yrs., mos., or days) 7 9 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give county)
(d) Street No. Grand Shepherd Convent - Mount and Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. Mary Rose Coyle

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/12/1869

8. AGE: Years	Months	Days	If less than one day
76	—	18	hr. min.

9. Birthplace Dushore Pa (Town, county, and state)
10. Usual Occupation Nun
11. Industry or business

FATHER
12. Name Francis Coyle
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Cutler
15. Birthplace Pennsylvania

16 (a) Informant Sisters of the Good Shepherd
(b) Address Mount and Hollins Sts
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd
18 (a) Funeral director Foley & Lafayette
(b) Address 921 E. Eight St.
19 (a) (Date received by Registrar) MAY 2 1945 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1945, at 6:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to Arteriosclerotic CV Disease
Other Conditions Fracture Rt. Hip.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 7/12/45 at approximately 9 A.M.
(b) Where did injury occur Mount and Hollins St
(c) Did injury occur at home, on farm, industrial place, in public place? Goods Shepherd Convent (Specify) At work? No
(d) Means of injury Fall to floor during window
23. Signature C. J. Fuhrmann M.D.
Medical Examiner.
Date signed 7/30/45

628464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ 628464 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Chesapeake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hudgins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Retired

FATHER
12. Name Carlos R. Hudgins
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Collins
15. Birthplace N.Y. City

16 (a) Informant Charles J. Hudgins
(b) Address 2310 Barclay st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location E. North ave.

18 (a) Funeral director Wm C Moran
(b) Address 3600 E Baltimore St

19 (a) MAY 2 1945 (Date rec'd by reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 19 45, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Autopsy (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypertrophied
Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schaefer M.D. Medical Examiner
Date signed 5/1/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5-0

G28465
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Elbens Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Elbens Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence A. Phillips

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John A. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1896

8. AGE: Years 48 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Balto Md (town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Albert Jacobs
13. Birthplace Md

MOTHER 14. Maiden Name Alice Burk
15. Birthplace Harpers Ferry W. Va

16 (a) Informant John A. Phillips
(b) Address 1620 Elbens Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location C.A. Co

18 (a) Funeral director C. Howard Evans
(b) Address 1460 Edmondson Ave

19 (a) MAY 2 1945 (Date rec'd by local registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to April 30 1945 and that I last saw him alive on April 30 1945

Immediate cause of death Exhaustion — Duration 5 days
Due to Carcinoma — Duration Indefinite
Due to of Breast & Liver
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. E. L. Campbell M. D.
Address 1644 Hanover St Date signed May 2 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

628466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

628466 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 S. Montford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 S. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Victoria Gurbelski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Walenty Smiegowski

13. Birthplace Poland

MOTHER 14. Maiden Name Catherine Ohalo

15. Birthplace Poland

16 (a) Informant Joseph Gurbelski

(b) Address 619 S. Montford.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern Ave

19 (a) MAY 2 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1943 to April 29 1945 and that I last saw h/Er alive on April 29 1945

Immediate cause of death ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Drenga

Address 209 Albert St Date signed 4/30/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28467 / 108

Registered No. G28467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mt Braeburn
(c) Hospital or institution: Mt Christ Hom + Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Katherine Webb.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Harry P. Webb.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-1859

8. AGE: Years	Months	Days	If less than one day
85	5	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Retired housewife
11. Industry or business At home

FATHER
12. Name Max Moser
13. Birthplace Bavaria

MOTHER
14. Maiden Name Katherine Deppino
15. Birthplace Genoa

16 (a) Informant Harry M. Webb (Son)
(b) Address 807 E. 22nd St. Balto-18 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1945 to 4-29 1945, and that I last saw h[illegible] alive on 4-29 1945.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions Arterio Sclerosis, Hypertension & Mild Cardiac Failure (Include pregnancy within 3 months of death)	

Date of operation none
Major findings of operation:
of autopsy: Pneumonia (Lobar)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address Calvert House Hosp. Date signed 4-30-45.

X

28468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. 28468

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 E. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Pouagiatopoulas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Clerk

FATHER
12. Name Charles
13. Birthplace Greece

MOTHER
14. Maiden Name Rose
15. Birthplace Greece

16 (a) Informant George Panos.
(b) Address 6607 Old Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Md
Location Greek Cemetery

18 (a) Funeral director Lambros Funeral Home Inc
(b) Address 439-440 E. North Ave.

19 (a) MAY 2 1945 (Date filed by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 8 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Valvular Endocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Prater M.D.
Medical Examiner.
Date signed April 29 1945

VS 151

G28469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G28469 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison - Linden
(c) Hospital or institution: Md. State Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Roland ave #11 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Rider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Rider.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1869

8. AGE: Years 75 | Months 6 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm J. Ball.
13. Birthplace Md.

MOTHER
14. Maiden Name Grace Davis.
15. Birthplace Md.

16 (a) Informant Charles H. Rider.
(b) Address 3524 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 3 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Eberting Ave.

19 (a) 1945 (Date rec'd by Registrar) (b) Lexington-Williams Mort

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 5:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1945 to April 30 1945 and that I last saw her alive on April 30 1945

Immediate cause of death: Bronchio-pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 4/30/45

ARMSTRONG

628470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 628470

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Armstrong
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4 1926

8. AGE: Years	Months	Days	If less than one day
19	6	27	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William Armstrong
13. Birthplace South Carolina

MOTHER
14. Maiden Name Jane Hartlow
15. Birthplace South Carolina

16 (a) Informant Janie
(b) Address 1017 S Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Sarah L Brown Sr
(b) Address 1050 Montgomery Street

19 (a) MAY 2 1945 (Date received by registrar) (b) Huntington Williams (Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1945 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1944 to 4/29 1945 and that I last saw h. living alive on 4/28 1945.

Immediate cause of death C-R Failure
Due to Pulmonary Tbc.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2
1

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Bell
Address Mercy Hosp. Date signed 4/29/45

X

G8471

472560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G8471

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-8-85

8. AGE: Years 59 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Neal Williams
13. Birthplace N. C.

MOTHER
14. Maiden Name Susie E.
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL May 2nd 45

17 (a) DUNN-N.C. (Burial, cremation, or removal) (b) Date thereof April 2nd 45 (month) (day) (year)
(c) Cemetery or crematory NC
Location NC

18 (a) Funeral director Edwin O Wilson
(b) Address 1400 Brantley

19 (a) MAY 2 1945 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 1 1945 at 3.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April-20 1945, to May - 1 1945, and that I last saw him alive on May - 1 1945.

Immediate cause of death Malnutrition — Duration 3 months

Due to Carcinomatosis — 1 year

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glen R Leymaster

Address Johns Hopkins Hospital Date signed 5/1/45 M. D.

628472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 628472

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 South Durham (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT KAISKE

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 219-05-7678

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances Kaiske
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-13-1892
8. AGE: Years 53 Months 3 Days 29 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Highway Engineer

FATHER
12. Name K Kaiske
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline
15. Birthplace Germany

16 (a) Informant Frances Kaiske
(b) Address 623 S. Durham

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory New National
Location Frederick Rd.

18 (a) Funeral director Lilly Zeller Jr
(b) Address 401 S Wolfe St

19 MAY 2 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/45 19 at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection of Injuries (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 5-2-45

G28473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28473 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Dist. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Past
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 E. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Kohler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Widowed

6 (b) Name of husband or wife Clara Kohler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1859

8. AGE: Years	Months	Days	If less than one day
86	0	24	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired Harness Maker

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Leon Bertpitch
(b) Address 404 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4-1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn A.A. Co.

18 (a) Funeral director Flynn & Flynn
(b) Address 1410 Light St.

19 (a) MAY 2 1945 (Date rec'd by Registrar) (b) Huntington Millmeister, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1945, at 6:24 M

21. I certify that I took charge of the remains described above, held an Autopsy, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Lubinski M.D. Medical Examiner.
Date signed 5/1/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628474 — BALTIMORE CITY HEALTH DEPARTMENT — 628474 Registered No.

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Athol - Baltimore 29
(c) Hospital or institution:
The Lunday Sanitarium 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) all her life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 N. Calvert St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lucy B. Webster

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife John F. Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-1866

8. AGE: Years	Months	Days	If less than one day
79	3	16	hr. min.

9. Birthplace Princess Anne, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Allen Cardiff
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Harris
15. Birthplace Md.

16 (a) Informant Mrs. Lawrence V. Folkes
(b) Address 302 N. Stafford Ave. Richmond, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 9 1945 (Date rec'd by Registrar) Thomas Williams, Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at 4 » M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1941, to May 1 1945, and that I last saw h-er alive on May 1 1945.

Immediate cause of death cerebral accident — Duration 1 hr

Due to cerebral accident — Duration years

Due to — Duration

Other Conditions Fracture of femur - all healed but head not in acetabulum as yet — Duration 1945

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rachel K. Lunday M. D.
Address The Lunday Sanitarium Date signed May 1, 1945

G28475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G28475 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 EAST ST.
(c) Hospital or institution: 5"
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO'
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. EAST St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W SWANN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife BESSIE (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1884

8. AGE: Years	Months	Days	If less than one day
60	6	24	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name ? SWANN
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Elizabeth Marshall
(b) Address 104 EAST St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1304 N. Central Ave.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MAY 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1945 to 4/29 1945 and that I last saw h. alive on 4/29 1945

Immediate cause of death Heart failure. — Duration

Due to Auricular Fibrillation

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris A. Dino M. D.
Address 118 Bryan's Rd. Date signed 5-2-45

G28476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G28476 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City morgue 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead on arrival
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country? Norway (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Carl Norman Jensen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife: HALDIS JENSEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1900

8. AGE: Years 44 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business

FATHER
12. Name /
13. Birthplace /

MOTHER
14. Maiden Name /
15. Birthplace /

16 (a) Informant Norwegian Consul
(b) Address 14th Court Bldg Balto Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave

18 (a) Funeral director Wilson Bork Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd by reg.) JUL 2 1945 (b) Huntington Williams, M.D.

VSH-51

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury 4/27/45 at ..... M.
(b) Where did injury occur? Pier #1 2nd Drydock, Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Found Drowned

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 27 1945

628477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 628477

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2224 Penna Ave

(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) one

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2224 Penna ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Diggs

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30. 1945

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name William Jackson

13. Birthplace unknown

MOTHER

14. Maiden Name Mildred Wood

15. Birthplace Whitestone, Va.

16 (a) Informant Mildred Diggs

(b) Address 2224 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Wm. J. Clightman Jr

(b) Address 6009 Prescott ave.

19 (a) (b) Registrant

MAY 2 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945, to May 1 1945, and that I last saw h[illegible] alive on April 30 1945

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Julian Shute M. D.

Address 1543 Penna Ave Date signed 5-2-45

X

G28478

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

G28478 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 E. Philadelphia
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steven Lookingbill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-9-44

8. AGE: Years	Months	Days	If less than one day
0 10 mo	9	23	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Philip Lookingbill
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sue Andrews
15. Birthplace Pennsylvania

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof May 2, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location York Pa.

18 (a) Funeral director Hay B. Crap c/o Philip Lookingbill
(b) Address Market Street, York, Pa.

19 (a) MAY 2 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to May 2 1945, and that I last saw him alive on May 2 1945

Immediate cause of death Cardiac failure — Duration 4 days

Due to Cardiac anomalies Congenital

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-1-45

Major findings of operation: Congenital heart anomalies, Mitral Patency

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor A. Najjar M. D.
Address Johns Hopkins Hosp. Date signed 5-2-45

X

G28479
472613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G28479
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 - E. Eohan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lisa Dotson Beddie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-40

8. AGE: Years	Months	Days	If less than one day
5	1	25	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Erwin Beddie
13. Birthplace N. C.

MOTHER
14. Maiden Name Elmeta Jones
15. Birthplace N. C.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2 45 (month) (day) (year)

(c) Cemetery or crematory
Location Rocky Mount N. Carolina

18 (a) Funeral director Mrs Robert A. Elliott, Dft
(b) Address 1129 N. Caroline St.

19 (a) (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 1 1945 at 4.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April - 21 1945 to May - 1 1945 and that I last saw her alive on May 1 1945

Immediate cause of death Overwhelming Infection — Duration 4 Days

Due to 2nd & 3rd Degree Burns — 9 Days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 21 at 3 P.M.
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury (Burns - Open Fire Flame contact)

23. Signature William C. Woods Jr.
Address Johns Hopkins Hosp. Date signed 5/1/45

VS 190

For Dr. A. T. Davis, by Howard S. Mallis M.D. Baltimore X

G28480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28480

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1463 Andrea Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1461 Andrea St: (Rear)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W Flickinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-05-7472

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha Flickinger

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug 20-1902

8. AGE: Years	Months	Days	If less than one day
42	8	10 1/2	..... hr. ..... min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual Occupation Metal Worker

11. Industry or business Mr. Reise.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Martha Flickinger
(b) Address 1463 Andrea St.

17 (a) Burial (b) Date thereof 5/4/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Frostburg Md
Location Maryland

18 (a) Funeral director Geo. A. Leinhart
(b) Address 525 N. Lyndhurst St

19 MAY 2 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1- 1945, at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Apoplexy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 5-1-45

VS 151

G28481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G28481 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 N. Bentalow St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara McFarland — Clara A. McFarlane

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-0495

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife. William McFarlane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 7, 1895

8. AGE: Years	Months	Days	If less than one day
49	5	24	hr. min.

9. Birthplace Wilmington, Del (Town, county, and state)

10. Usual Occupation Clerk - Finance Dept.

11. Industry or business U. S. Army

FATHER
12. Name Thomas J. Levey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susie J. Sloffer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Gladys Buckman
(b) Address Ocean City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Arlington National Cem.
Location Arlington, Va.

18 (a) Funeral director E. W. Ramonedec
(b) Address 4510 Liberty Heights Ave.

19 1945 (Date rec'd by registrar) (b) Arlington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945 at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hew death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Aorta

Due to Arteriosclerosis of Aorta

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Fratier M.D. Medical Examiner.
Date signed May 1 1945

X

628482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. 628482

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Madison ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11/4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John W. Clark
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/1849

8. AGE: Years 96 | Months 1 | Days 12/14 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business

FATHER
12. Name Thomas R. Ockerme
13. Birthplace md

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs Edith Conall
(b) Address 1208 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto.

18 (a) Funeral director William a Jackson
(b) Address 916 Penn ave

19 (a) (Date received by registrar) Huntington Williams, Mgr

MAY 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 45 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1945, to May 1 1945 and that I last saw h[illegible] alive on May 1 19 45

Immediate cause of death Chronic Nephritis — Duration: about 1 yr

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Pelletiau M. D.

Address 417 Hamilton Ave Date signed May 2 1945

X

G28183 ✗ ✓ G28183

BALTIMORE CITY HEALTH DEPARTMENT 83R Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County 1 Baltimore
(c) City or town Balto. 12 MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Dunkirk Rd.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Carroll Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Hannah Mooney Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1870

8. AGE: Years 74 yr. Months 7 Days 19 If less than one day hr. min.

9. Birthplace Balto MD
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Franklin Printing Co.

FATHER
12. Name Geo Watts
13. Birthplace Maryland

MOTHER
14. Maiden Name CAVALIER DILLAWAY
15. Birthplace BALTIMORE, MD.

16 (a) Informant G. LAWRENCE WATTS
(b) Address 8 DUNKIRK ROAD

17 (a) BURIAL (b) Date thereof 5/5/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans & Son Inc.
(b) Address 116-118 W. Mt. Royal Ave.

19 (a) MAY 3 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945; at 1 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 2 1945, and that I last saw h[illegible] alive on May 1 1945,

Immediate cause of death Cerebral Vascular Accident — Duration 5 hrs

Due to Hypertension — 10 yr

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Pakes M.D.
M. D.

Address Mercy Hosp. Date signed May 2 1945

VS. 150

X

628484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

628484 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 W. 25 St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Charles Jacob

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances T. Jacob
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1894

8. AGE: Years	Months	Days	If less than one day
50	7	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation District State Manager
11. Industry or business Calvert Distillery

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Frances B. Jacob
(b) Address 5 W. 25th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 112 W. Mt. Royal Ave

19 (a) MAY 3 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30- 1945, at 11:37 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun shot wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-30-45 at 9.20 P. M.
(b) Where did injury occur? Charles-Lafayette ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm

23. Signature Howard J. Weidein M.D.
Medical Examiner.
Date signed 5-1-45

X

628485 628485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 E. 35th St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. 35th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Sr Eisinger

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband George E. Eisinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24th 1860

8. AGE: Years: 84 | Months: 9 | Days: 8 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Casper Schmidt
13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Roerich
15. Birthplace Germany

16 (a) Informant Robert Eisinger
(b) Address 613 E. 35th St

17 (a) Burial (b) Date thereof 5/4/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Prospect Hill
Location Towson Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 3 1945

Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1945, at 6 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1943 to 5-2 1945 and that I last saw h[illegible] alive on 5-2 1945.

Immediate cause of death: Chronic Interstitial nephritis — Duration: 4 yrs

Due to: Hypertensive degeneration — Duration: 4 day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul F. Miller

Address 1509 N Broadway Date signed M. D.

G28486 REUMER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G28486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden

(c) Hospital or institution: Maryland General Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1925 Linden ave. #17

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) **FULL NAME** Margaret Reumer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1943

8. AGE: Years	Months	Days	If less than one day
1	5	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER

12. Name Stanley Reumer

13. Birthplace Baltimore

MOTHER

14. Maiden Name Margaret Reumer

15. Birthplace Baltimore

16 (a) Informant Mr. Stanley Reumer

(b) Address 1925 Linden Ave

17 (a) Burial (b) Date thereof May 4 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore

18 (a) Funeral director Philip Herrig Sons

(b) Address 2024 Orleans St

19 (a) MAY 3 1945 (b) Huntington Williams
(Date) Registrar Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 12 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 22 1945 to May 2 1945; and that I last saw her alive on May 2 1945

Immediate cause of death Tuberculous Meningitis — Duration 2 wks.

Due to Pulmonary Tuberculosis

Due to —

Other Conditions Lateral Sinus Thrombosis (Rt.)
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury —

23. Signature Morton E. Strobel M. D.

Address Md. Genl. Hospital Date signed 5/2/45

28487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93-D

G28487 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Carroll Av
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Carroll Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Leary

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thos. J. Leary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1862

8. AGE: Years	Months	Days	If less than one day
82	10	18	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Schulert
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Wm Leary
(b) Address 1114 Carroll Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Thomas Kenney
(b) Address 1600 Hollins St

MAY 3 1945 Huntington Williams M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1939, to April 30 1945, and that I last saw h-- alive on April 30 1945.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Cardiac Hypertrophy	
Due to Cardiac Decompensation	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent M Mesaros M.D.
Address 1403 S. Charles St Date signed 5/2/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1112

Registered No. 628488

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 S. Sharp St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Constance Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/1942

8. AGE: Years	Months	Days	If less than one day
2	8	15	hr. min.

9. Birthplace Reidsville, N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name Mollie Roach
15. Birthplace N. C.

16 (a) Informant Mollie Roach
(b) Address 220 S Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location.....

18 (a) Funeral director James A Adams
(b) Address 142 W Still St

19 (a) MAY 2 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 3:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infection of Lungs

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Gratton M.D. Medical Examiner.
Date signed May 2 1945

G28489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 492

G28489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4612 Schenley Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4612 Schenley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MERRYMAN DASHIELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William Dashiell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1870

8. AGE: Years	Months	Days	If less than one day
74	8	21	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles H. Merryman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mollie Taylor
15. Birthplace Balto., Md.

16 (a) Informant Mr. C. Harvey Merriman
(b) Address 3411 Grantley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

MAY 3 1945 (b) Date rec'd by Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944, to May 1 1945.
and that I last saw h.er alive on May 1 1945.

Immediate cause of death	Duration
Emaciation & dehydration	5 days.
Due to Intestinal obstruction; peritoneal implants from	5 days.
Due to carcinoma of ovary	6 mo.
	16 yrs.
	?

Other Conditions Arteriosclerosis & diabetes mellitus.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robt B. Wright M. D.
Address Medical Arts. Date signed 5/3/45

Washington Williams, Registrar

VS 150

G28490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

G28490 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 774 W. Cross St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 774 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Real

3 (b) If veteran, name war

(c) Social Security Account No. 217-03-6659

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1893

8. AGE: Years	Months	Days	If less than one day
51	10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Box Maker

11. Industry or business

FATHER
12. Name Casper Real
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma Gainsway
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Emma Real
(b) Address 774 W. Cross St.

17 (a) Burial (b) Date thereof May 4-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves. Washington

19 (a) MAY 3 1945 Registrar
(Date of this registration)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945 at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5-2-45

G28491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 80B

Registered No. G28491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Dover Street (If rural, give location)
(e) Citizen of foreign country? N/A (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas William Beyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) February 5 1945

8. AGE: Years	Months	Days	If less than one day
	2	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry F. Beyer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Agnes Wright
15. Birthplace Balto. Md.

16 (a) Informant Henry F. Beyer
(b) Address 1810 Dover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Leach-Schwal
(b) Address 210 Frederick Ave

19 MAY 3 1945 (Date rec'd by registrar) Arlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1945, at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1945, to 5/2 1945, and that I last saw h[illegible] alive on 5/1 1945.

Immediate cause of death Cardiac Respiratory Arrest

Due to Encephalitis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 5/2/45

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 B Registered No. 628492

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Chelsea Terrace
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Rea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Estelle Brown

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) October 20, 1869

8. AGE: Years 75 | Months 6 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Portsmouth, Va. (Town, county, and state)

10. Usual Occupation Insurance agent

11. Industry or business

FATHER
12. Name James S. Rae
13. Birthplace Va

MOTHER
14. Maiden Name Katherine Stokes
15. Birthplace Va

16 (a) Informant William F. Giles
(b) Address 2211 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (Date received by registrar) MAY 3 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 9.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1945 to May 2 1945 and that I last saw h.. alive on April 1 1945

Immediate cause of death: Carcinoma of tongue — Duration: 4 mos.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Rea M. D.
Address 612 W. 40th St. Date signed

VS 150

G28493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G28493

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 Underwood Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Joseph Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-1871

8. AGE: Years	Months	Days	If less than one day
74	1	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Wm H Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary J. De Valgin
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Joseph Thompson
(b) Address 4416 Underwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto Co.

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1910 Eutaw Place

19 MAY 3 1945 (b) Huntington Williams (Date rec'd by Reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1945, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1945 to 5-1 1945 and that I last saw her alive on 5-1 1945.

Immediate cause of death	Duration
PAPILLO CARCINOMA OF BLADDER	
Due to	
Due to	
Other Conditions EXTENSION OF PAPILLO-CARCINOMA INTO THE BROAD LIGAMENTS. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address The Church Home + Hosp. Date signed 5-1-45

G28494

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28494

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1550 Leslie St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1550 Leslie St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME 1550 Leslie Cora Watkins
3 (b) If veteran, name war —
3 (c) Social Security Account No. None
4. Sex F
5. Color or race Col
6 (a) Single, married, widowed, or divorced W
6 (b) Name of husband or wife Frank
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 9 1883
8. AGE: Years 61 Months 8 Days 22 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Julius Harps
13. Birthplace Md

MOTHER
14. Maiden Name Mary Sheep
15. Birthplace Md

16 (a) Informant Bertie Brown
(b) Address 1550 Leslie St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/45 (month) (day) (year)
(c) Cemetery or crematory Coopers Chapel
Location Calvert Co. Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1300 Pleasant

19 (a) MAY 3 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1945 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1945 to 5/1 1945 and that I last saw him alive on 5/1 1945

Immediate cause of death Cerebral Apoplexy — Duration

Due to Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo B. Kelson M. D.
Address 350 Pleasant Date signed 5/3/45

VS 150

G28495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28495

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Mc Henry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Dinwiddie
(c) City or town Petersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosinda ~~Lisenda~~ C. Tarleton

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isaac A.

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan 16 1874

8. AGE: Years 71 | Months 3 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Arlington N. Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name D. C. Flow
13. Birthplace N.C.

MOTHER
14. Maiden Name Amanda E. Miller
15. Birthplace N.C.

16 (a) Informant Isaac A. Tarleton
(b) Address Petersburg Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Petersburg Virginia

18 (a) Funeral director Pratt & Bottom Wheeler
(b) Address Pratt & Tucker Sts

19 (a) MAY 3 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 7 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1945 to 5/3 1945, and that I last saw h... alive on ... 19...

	Duration
Immediate cause of death Acute Cardiac dilatation 5 days	
Due to Hypertension Chronic myocarditis	5 yrs
Due to Arterio Sclerosis Senility	5 yrs
Other Conditions	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Fulton M. D.
Address 4 N. Fulton. Date signed

628496 Mr. 637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

628496 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Knight

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife Mollie G. Newport. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1870

8. AGE: Years	Months	Days	If less than one day
75	3	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Electro - Plater
11. Industry or business Nolan & Co.

FATHER
12. Name Thomas Knight
13. Birthplace Md

MOTHER
14. Maiden Name Elmira Shepard
15. Birthplace Md

16 (a) Informant Mrs William Knight
(b) Address 1723 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Ave.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 MAY 3 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1945, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1945, to 5-2 1945, and that I last saw h(M) alive on 5-2 1945.

Immediate cause of death: Cachexia acute Carcinomatosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Inoperable Cancer
Major findings of operation: 4-29-45
of autopsy: Widespread Cancer

Duration
? months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers, M.D.
Address Franklin Sq. Hosp. Date signed 5/3/45

628497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463 Registered No. 628497

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 440 S. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 440 S. Stricker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lilly V. King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1881

8. AGE: Years 63 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Sewing Machine Operator

11. Industry or business

FATHER 12. Name Benjamin L. King

13. Birthplace Md.

MOTHER 14. Maiden Name Margaret E. Purdy

15. Birthplace Md

16 (a) Informant Mrs Maggie Dieus

(b) Address 1726 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md

18 (a) Funeral director Harry W. Loitzke

(b) Address 4101 Edmondson Ave

19 (a) MAY 3 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to May 1 1945 and that I last saw her alive on April 28 1945

Immediate cause of death	Duration
Carcinoma of Pancreas	
Due to	
Due to	
Other Conditions Generalized metastasis	

(Include pregnancy within 3 months of death)

Date of operation Nov 10 - 1944

Major findings of operation: Carcinoma of Pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas S. Bowyer M. D.

Address Med Arts Bldg Date signed 5-1-45

28498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. 28498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 E Mt Pleasant Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 E Mt Pleasant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Francis Hart

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Mamie Hart 6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 1/20/1877

8. AGE: Years 68 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Cook Engineer

11. Industry or business City of Baltimore

FATHER
12. Name Edward Hart
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Healy
15. Birthplace Ireland

16 (a) Informant Mrs Mark F Hart
(b) Address 1 E Mt Pleasant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director D. F. Aherne Sons
(b) Address 1318 Light St.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MAY 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 1 1945, and that I last saw him alive on April 30 1945.

Immediate cause of death Myocardial Insufficiency

	Duration
Due to	
Due to	
Other Conditions Myocarditis, Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature John G. Schmeck
Address 1337 S. Charles St Date signed 5/2/45 D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HAIRE

628499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

628499 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 C Randall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city limits write RURAL and name town)
(d) Street No. 7 C Randall St (Or other location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Patrick Haire

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary C Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 72 | Months — | Days — | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Iron

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Ireland

MOTHER 14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mary E Kelly
(b) Address 7 C Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director John F Welsh
(b) Address 131 S Eutaw St

19 MAY 3 1945 (Date rec'd by local reg.) (b) Huntington Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to May 1 1945, and that I last saw him alive on April 30 1945

Immediate cause of death
Central Apoplexy.
Due to
Due to
Other Conditions Arteriosclerosis; Hypertension. Myocarditis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No. While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G Schenuit
Address 1337 S Charles St Date signed 5/2/45

X

628500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 628500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 37 S. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 S. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Gallop

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Thomas Gallop
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) April 22, 1863

8. AGE: Years	Months	Days	If less than one day
82		9	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Grady
13. Birthplace Ireland.

MOTHER
14. Maiden Name Elizabeth Dudley
15. Birthplace Va.

16 (a) Informant Thomas Gallop.
(b) Address 37 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery
Location Alexandria, Va

18 (a) Funeral director Howard V. Blight Jr.
(b) Address 4914 Belair Road.

MAY 2 1945 Registrar

Dec'd is

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945 at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30/45 to 4/30/45 and that I last saw h[illegible] alive on 4/30/45

Immediate cause of death: Cerebral Hemorrhage

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
2 days
7 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Gordon
Address 40 S. Edmondson Date signed 5/3/45

VS 150

628501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

628501
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 E. Lafayette Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gustave A. Wetzel

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-10-2466

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine E. Kreuzer

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1876

8. AGE: Years 68 | Months 6 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation City Employee

11. Industry or business Water Dept. Baltimore

FATHER
12. Name John E. Wetzel
13. Birthplace Germany

MOTHER
14. Maiden Name Lizzette M. Bierman
15. Birthplace Germany

16 (a) Informant Mrs. Josephine E. Wetzel
(b) Address 1504 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 MAY 3 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st, 1945, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1945 to May 1 1945. And that I last saw h— alive on May 1 1945

Immediate cause of death: Respiratory & Cardiac Paralysis — Duration

Due to: Bronchopneumonia

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr S. Wallenstein M. D.

Address 2042 Eutaw Pl Date signed 5-2-45

G28502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G28502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE CAMPBELL SEALOR

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-09-8589

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1898

8. AGE: Years 47 | Months 4 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Joseph Wm. Sealor
13. Birthplace York Co. Pa.

MOTHER
14. Maiden Name Mary Campbell
15. Birthplace Phila. Pa.

16 (a) Informant Willard Sealor (Brother)
(b) Address 1832 Rutland Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5-4-45 (month) (day) (year)
(c) Cemetery or crematory Slatesville Cemetery
Location Delta, Pa.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 3 1945

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary disease
Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen Medical Examiner. M.D.
Date signed 5-2-45

X

R. Campbell 1644 Hanover st So 0059 G28503

G28503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Woodall st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Woodall st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand L. Hepfding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed or~~ divorced. Married

6 (b) Name of ~~husband or~~ wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1867

8. AGE: Years 77 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name (Unknown) Hepfding
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. F. Hepfding
(b) Address 1418 Woodall st.

17 (a) Burial (b) Date thereof 5/4/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date received by registrar) MAY 3 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to May 1 1945 and that I last saw h ~~alive~~ on May 1 1945

Immediate cause of death	Duration
Acute Dilatation of Heart	2 days
Due to Mitral Regurgitation	Indefinite
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Hanover Date signed 5/2/45

628504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X164R

Registered No. 628504

Resp. allowed 426 E. Pratt Street

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 W. Walnut St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Hanna

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address
MAY 3 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18- 1945, at 6.40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-18-45 at 6 P.M.
(b) Where did injury occur? Harbor - Pier 2 Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Asphyxiation - drowning

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 4-19-45

VS 151

2082

G28505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. G28505

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 3 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 34 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 3 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21/45 19..., at 10 20 M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulbenski M.D. Medical Examiner.
Date signed 4/22/45

2083

8506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G28506 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen Proving Ground
(If outside city or town limits, write RURAL and give town)
(d) Street No. Staten Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Sonnenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-28-45

8. AGE: Years | Months | Days | If less than one day: 8 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard J. Sonnenfeld
13. Birthplace

MOTHER
14. Maiden Name Birkhead
15. Birthplace

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAY 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 3 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945 to April 29 1945 and that I last saw h[illegible] alive on April 29 1945

Immediate cause of death	Duration
(a) Respiratory failure	24 hrs
Due to (b) Tuberculosis	
Due to (c)	
Other Conditions Contributory to Death but not related to the disease causing it	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kerr M.D.
Address J. Hopkins Hosp Date signed 4-29-45

VS 150

2681

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28507
472449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Atlanta (If outside city or town limits, write RURAL and give town)
(d) Street No. 1453 West View Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rubye Faye McLeod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-30-15

8. AGE: Years	Months	Days	If less than one day
29.	10	3	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Allen D Hart
13. Birthplace Ga

MOTHER
14. Maiden Name Maggie J Spangate
15. Birthplace Ga

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5 3 45 (month) (day) (year)
(c) Cemetery or crematory
Location Atlanta Ga

18 (a) Funeral director Wm J Fuller & Son
(b) Address North & Pac. Avenues,

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MAY 3 1945
YS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945 at 3.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to May 3 1945 and that I last saw h[illegible] alive on May 3 1945.

Immediate cause of death Post-Operative Shock — Duration 3 Hours
Due to Pulmonary Tbc. Thoracoplasty (1st 3 Ribs) — 8 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 5/1/45
Major findings of operation Pulmonary Tbc C Thoracoplasty - 1st 3 Ribs
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr. M.D.
Address Johns Hopkins Hospital Date signed 5/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33B

G28508
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Wilmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Marsh Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Karen Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-44

8. AGE: Years | Months: 8 | Days: 29 | If less than one day: hr. min.

9. Birthplace Wilmington Delaware
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred Wise
13. Birthplace N.Y.

MOTHER
14. Maiden Name Emmie Hall
15. Birthplace Delaware.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 '45 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Wilmington, Del.

18 (a) Funeral director John O. Mitchell Son
(b) Address 1900 Eastern Place.

19 (a) 1945 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 3 1945 at 5.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945 to May - 3 1945 and that I last saw h.. alive on May - 3 1945

Immediate cause of death: Respiratory failure — Duration: 3 hrs
Due to: Influenza bacillus — Duration:
Due to: Bronchopneumonia — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pathological

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert Lange
Address Date signed

G28509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

Registered No. G28509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 746 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jay L. Gammerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	✓

6 (b) Name of husband or wife ✓

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) March 17, 1945

8. AGE: Years	Months	Days	If less than one day
	1	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Gammerman
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Alice Berman
15. Birthplace Md.

16 (a) Informant Louis Gammerman
(b) Address 746 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave

19 (a) MAY 4 1945 (Date received by registrar) (b) Livingston Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945, at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
2nd Medical Examiner.
Date signed May 3 1945

628510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123B

Registered No. 628510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rudwood & Greene
(c) Hospital or institution: University Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gertrude Parker

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace MD
(Town, county, and state)

10. Usual Occupation NURSE

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Runda
(b) Address Univ Hosp

17 (a) Burial, cremation, or removal (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Loudon Park Ave

18 (a) Funeral director Tilhom & Dye
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 1945, at 1158 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1945 to 5/3 1945 and that I last saw h[illegible] alive on 5/3 1945

Immediate cause of death Uremia — Duration

Due to Urinary suppression, cancer of bladder, inoperable

Due to

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto K. Eppig, M.D.

Address Univ. Hosp. Balto Md Date signed M. 5 D. 3/45

628511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 628511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 S. Binney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bronislawa, Bernice, Kallner

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2606

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19-1914

8. AGE: Years	Months	Days	If less than one day
30	10 11	14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kacala
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Balen
15. Birthplace Poland

16 (a) Informant Albert T. Kallner
(b) Address 1119 S. Binney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George R. Weber
(b) Address 720 S. Bond street

MAY 4 1945
(Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1945, at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4:30 A.M. May 3, 1945 M.
(b) Where did injury occur? 1119 S. Binney St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? ---
(d) Means of injury Unlit jets on kitchen stove

23. Signature Howard J. Malone M.D.
Medical Examiner.
Date signed 5-3-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G28512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2414 Leutertown Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2414 Leutertown Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Bass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Tailor (self)

11. Industry or business

FATHER 12. Name Benjamin

13. Birthplace Russia

MOTHER 14. Maiden Name Leah

15. Birthplace Russia

16 (a) Informant L. Myers

(b) Address 20 So Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 4 45 (month) (day) (year)

(c) Cemetery or crematory Sinai Hebrew

Location Wine Orange Md.

18 (a) Funeral director

(b) Address 1402 E Monument St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 1 MAY 4 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to May 3 1945, and that I last saw him alive on 5/3 1945.

Immediate cause of death: Acute Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Boillard Appleford

Address 3511 Leutertown Rd Date signed 5/3/45

X

G28513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G28513
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5018 Dennure Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORRIS SALKIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-4991

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months 0 | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Jacob -
13. Birthplace Russia

MOTHER
14. Maiden Name Rynah -
15. Birthplace Russia

16 (a) Informant Mrs. Rena Salkin
(b) Address 5018 Dennure Ave

17 (a) Burial, cremation, or removal Sinai (b) Date thereof 4-6-45
(month) (day) (year)
(c) Cemetery or crematory Windsor Mills Rd.
Location

18 (a) Funeral director Jack Newmark
(b) Address 1398 E. Balto St

19 (a) (Date received by registrar) MAY 4 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3-45, 1945, at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 5-3-45 19 45.

Immediate cause of death	Duration
Cardiac - respiratory arrest.	
Due to Acute pulmonary edema.	
Due to Coronary thrombosis - coronary sclerosis	
Other Conditions Benign prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Konrad Fischer M.D.
Date signed 5-3-45

G28514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G28514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette and Johns Street

(c) Hospital or institution: Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Hospital for Women of Maryland 2738 Pelham ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ~~Paul John Jennings~~ Paul John Jennings

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-29-45

8. AGE: Years	Months	Days	If less than one day
		3	10 hrs min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Paul John Jennings

13. Birthplace Baltimore, Maryland.

MOTHER 14. Maiden Name Margaret Katherine Kirsch

15. Birthplace Baltimore, Maryland

16 (a) Informant Paul John Jennings-father

(b) Address 2738 Pelham Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road.

18 (a) Funeral director Charles E. Schimunek.

(b) Address 2601-03 East Madison Street.

MAY 4 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 5:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29-45 19 , to 5-3 , 1945, and that I last saw him alive on 5-2 1945

Immediate cause of death Asphyxia — Duration

Due to Aspiration

Due to Prematurity

Other Conditions — Hemorrhages in lungs. (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Atelectasis left lung.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. P. Sullivan M. D.

Address Women's Hosp. Date signed 4/30/45

628515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 628515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette Ave & John Street

(c) Hospital or institution: Women's Hosp. 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Hospitalization Women of Maryland 2738 Pelham Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carl George Jennings.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/45

8. AGE: Years | Months | Days: 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Paul John Jennings

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Margaret Katherine Kirsch

15. Birthplace Baltimore, Maryland

16 (a) Informant Paul John Jennings-father

(b) Address 2738 Pelham Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Charles E. Schimunek.

(b) Address 2601-03 East Madison Street

MAY 4 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29-45 1945, to 5-3 1945.

and that I last saw him alive on 5-3 1945.

Immediate cause of death Asphyxia — Duration

Due to Aspiration

Due to Prematurity

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: no autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Sullivan M. D.

Address Women's Hosp. Date signed 5/3/45

X

628516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

628516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 N. Gilmor St.
(c) Hospital or institution:
16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Susan Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1858

8. AGE: Years	Months	Days	If less than one day
86	9	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Past Grand
11. Industry or business Secretary of I.O.O.F.

FATHER
12. Name John M. Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Allen
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary Isaac
(b) Address 706 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 1003 W. Baltimore St.

19 MAY 4 1945 Huntington Williams M.D. Registrar
Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944, to May 2 1945 and that I last saw h. in alive on May 2 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular disease	2
Due to Chronic Myocarditis	
Due to	
Other Conditions Arteriosclerosis of both legs.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert J. Rhodes M.D.
Address 2302 Edmondson Ave. Date signed

VS 150

G28517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3024 Northern Parkway
(c) Hospital or institution:
27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Bayonne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNIE PETTIT DeHOFF

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jesse B. DeHoff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1872

8. AGE: Years 72 | Months 6 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Pettit
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Polton
15. Birthplace Balto., Md.

16 (a) Informant Mrs. James L. West, daughter
(b) Address 3024 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ... (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) MAY 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945, at 5.55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945 to May 3 1945, and that I last saw h[er] alive on May 3 1945

Immediate cause of death Cerebral Hemorrhage (Apoplexy) — Duration May 3 1945

Due to

Due to

Other Conditions Arteriosclerosis — Duration a number of years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Green M. D.
Address 3009 Eutaw Pl. Date signed 5/3/45
Baltimore 14 Md. X

G28518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G28518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Wilhelm St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Wilhelm St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank H. Boettinger

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-69-6208

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Boettinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 1886

8. AGE: Years 59 | Months — | Days 98 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business

FATHER 12. Name Henry Boettinger

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Margaret Schleicher

15. Birthplace Germany

16 (a) Informant Mrs Anna Boettinger

(b) Address 2011 Wilhelm St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md

18 (a) Funeral director J. D. Tippett & Son

(b) Address Baltimore Monroe St

19 (a) (Date received by registrar) MAY 4 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 at 1:50 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/1 19 45 to 5/5 19 45 and that I last saw h[illegible] alive on 5/2 19 45

Immediate cause of death Carcinoma of Liver — Duration 4 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Benjamin Miller M.D. M. D.

Address 20 E. Wilkens Date signed 5/4/45

Huntington Williams, M.D.

ave X

G28519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G28519 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 BRIGHTON STREET
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 BRIGHTON STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES William McKINSTRY

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 705-05-6000

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: EMMA T.
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) AUG. 31-1871

8. AGE: Years 73 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business BALTIMORE & OHIO RAILROAD

FATHER
12. Name JOHN McKINSTRY
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden Name ALICE MICHAEL
15. Birthplace FREDERICK MARYLAND

16 (a) Informant EMMA T. McKINSTRY
(b) Address 2906 BRIGHTON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-5-45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVENUE

18 (a) Funeral director CHESTER WEBER
(b) Address 2503 EDMONDSON AVE.

19 (a) (Date received by registrar) (b) Registrar

MAY 4 1945 Huntington Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1943, to May 2 1945, and that I last saw him alive on May 2 1945.

Immediate cause of death: Hypertensive Cardio-Vascular Renal Disease — Duration: 7 years
Due to: Uremia Poisoning — 3 weeks
Due to: Arteriosclerosis
Other Conditions: None
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Ackerman M. D.
Address 1201 Poplar Grove St. Date signed 5-3-45

VS 150

G28520

G-22714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G28520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John St
(c) Hospital or institution: Hospital for Women of Md. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Lake Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Goldstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1945

8. AGE: Years | Months | Days: 14 | If less than one day: 7 hr. 13 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard M. Goldstein
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Beatrice Gordon
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAY 3 1945

18 (a) Funeral director
(b) Address Commissioner of Health

19 MAY 4 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1945 to April 28 1945, and that I last saw him alive on April 28 1945

Immediate cause of death: Asphyxia — Duration

Due to: Premature birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. P. Sullivan M. D.
Address Women's Hosp. Date signed 5/3/45

12686

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G28521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Rochille Terrace (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ruth Evelyn Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1883

8. AGE: Years	Months	Days	If less than one day
61	8	29	...hr. ...min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Robert J. Cullen

13. Birthplace ?

MOTHER 14. Maiden Name Mary Rogers.

15. Birthplace Baltimore Md

16 (a) Informant Evelyn Gibson

(b) Address 502 Oakland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1945 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount & Oliver Sts

18 (a) Funeral director John A Moran

(b) Address 5000 Reisterstown Rd

19 (a) MAY 4 1945 (Date rec'd by registrar) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1945, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury.....at.....M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....

(d) Means of injury.....

23. Signature Robert Lee Feehan M.D. Medical Examiner.

Date signed May 2 1945

VS 151

28522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

Registered No. 28522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 555 Robert Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 555 Robert St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Emery Young

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1870

8. AGE: Years 74 | Months 6 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles Fobbs
13. Birthplace Md

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Otha Young
(b) Address 555 Robert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Pressman St

19 (a) MAY 4 1945 Huntington Williams M.D. (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945, to May 1 1945, and that I last saw her alive on May 1 1945.

	Duration
Immediate cause of death acute cardiac failure	24 hrs
Due to cerebral embolism	15 days
Due to arteriosclerotic heart disease	18 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Mulberry St Date signed 5.3.45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28523

BOWMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28523

Registered No. 831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Evesham Ave
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Evesham ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Anna Bowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Fem.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrew G. Bowman.

6 (c) If alive, give address

7. Birth date of deceased (mo., day, yr.) Oct. 2- 1870

8. AGE: Years 74 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Loganville York Co Pa.
(Town, county and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Albert J. Gladfelter

13. Birthplace York Co Pa.

MOTHER 14. Maiden Name Sarah A. Klinedinst

15. Birthplace York Co Pa.

16 (a) Informant Wm. J. B. Crew.

(b) Address 603 Evesham Ave. Balto. Md.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)

(c) Cemetery or crematory Shiffler Cemetery

Location Shiffler Cemetery York Co Pa

18 (a) Funeral director C. F. Kolb

(b) Address York Pa. Huntington Williams, Mgr.

MAY 4 1945 (b) (Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 859 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1937, to May 3. 1945, and that I last saw h alive on May 4 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Day

Due to: Hypertension — Duration: not known 1937 or former

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Roberts M. D.

Address 6100 York Road Date signed May 10 1945

VS 150

X

628524

AB-92163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

628524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 14days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 207 N. Montford Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matthew Newton Ennis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28-1921

8. AGE: Years	Months	Days	If less than one day
23	5	2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard Newton

13. Birthplace Md.

MOTHER 14. Maiden Name Pearl Ennis (D)

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial, cremation, or removal (b) Date thereof May 5-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Baltimore Md.

18 (a) Funeral director Robert E Hillen

(b) Address 1515 McElderry Ave

19 (a) Date rec'd by Local Registrar MAY 4 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at 10.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 19 45, to 4-30 19 45. and that I last saw h. alive on 4-30- 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis Bilateral	1 year
Due to	
Due to	
Other Conditions Adrenal T.b.c.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harold Hilton M. D.

Address Balto City Hosp Date signed 5/2/45

G28525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115B

Registered No. G28525

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St Jo

(c) Hospital or institution: n

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Anne A rundel

(c) City or town Pasedena (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine R Ellison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: None.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1867

8. AGE: Years 78 | Months 1 | Days 3 | If less than one day: hr. min.

9. Birthplace Anne Arundel Co. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER

12. Name John Francis Ellison

13. Birthplace Anne Arundel Co. Md.

MOTHER

14. Maiden Name Sarah E. Stinchcomb

15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Mrs. Emma V. Dunlap.

(b) Address Pasadena Md R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6, 1945 (month) (day) (year)

(c) Cemetery or crematory Magothy Church Yard.

Location Jacobsville, Md

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie Md.

MAY 4 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 '45, to 5/3 1945, and that I last saw her alive on 5/3 1945.

Immediate cause of death: Fulminating toxemia and dehydration — Duration

Due to Staphylococcic infection of the pharynx

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Emg cons J Riley M. D.

Address St Joseph's Hosp. Date signed 5/3/45

VS 180

G28526 Moser G28526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38d
(e) Length of stay in Baltimore (yrs., mos., or days) 38d

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Bridgeton (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward F Moser.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Anne Moser.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-1 1892

8. AGE: Years 52. | Months 4 5 | Days 4 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Farmer.
11. Industry or business

FATHER 12. Name Henry Moser.
13. Birthplace Virginia

MOTHER 14. Maiden Name Anna Brown.
15. Birthplace Virginia

16 (a) Informant Mrs. M. A. Moser.
(b) Address Bridgeton Pa Route 1

17 (a) Burial, cremation, or removal (b) Date thereof May 7 1945 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Shane Md

18 (a) Funeral director Edward Walls
(b) Address Bridgeton Pa

19 (a) MAY 4 1945 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1945, at 12:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1945 to 5-4 1945, and that I last saw him alive on 5-4 1945.

Immediate cause of death: cardio-resp failure — Duration

Due to Hypernephroma.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Brigitte Nelson M. D.
Address Union Mem. Hosp. Date signed 5-4-45

G28527 c of y — Eisenbrode ✓ — G28527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1172

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Elmlawn Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edgar Eisenbrode

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Eisenbrode
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 21, 1870

8. AGE: Years 75 | Months - | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Statuary Engraver
11. Industry or business

MOTHER / FATHER
12. Name James Eisenbrode
13. Birthplace Md.
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mary Eisenbrode
(b) Address 2033 Elmlawn Lane

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Crockett
(b) Address 1345 N. Chester St

19 (a) MAY 4 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 19 45 at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1945 to 5/3 1945 and that I last saw h[illegible] alive on 5/3 1945

Immediate cause of death: Cardio - resp failure.
Duration
Due to Myocardial infarction.
Due to Post operative complications.
Other Conditions Art. scl. H. Dis.

(Include pregnancy within 3 months of death)
Date of operation 4/13/45
Major findings of operation: Ruptured peptic ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X Dr. L. M. Greenberg M. D.
Address Sinai Hospital Date signed 5/3/45

628528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

628528 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Elwood Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Cecilia O'Melia

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martin

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 39 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Cieslik
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Pustisiewska
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Oszewski
(b) Address 1930 Eastern Ave

19 (a) ..... (b) Entered by ..... Williams M.D. Registrar

MAY 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 12:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945 to May 4 1945, and that I last saw her alive on May 4 1945

Immediate cause of death Acute liver necrosis — Duration .....

Due to Alcoholism

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Albert A. Kattan M.D.
Address Johns Hopkins Hosp Date signed 5/4/45

X

G23529 X2 G28529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Doolittle Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Mary Lee Stritzinger
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE
4. Sex female
5. Color or race White
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) NOV. 29 1944
8. AGE: Years ..... Months 5 Days 4 If less than one day ..... hr. ..... min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business .....
FATHER 12. Name A. J. Stritzinger
13. Birthplace BALTO. MD.
MOTHER 14. Maiden Name Barbara
15. Birthplace BALTO. MD.
16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 4/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Leila J. Lee
(b) Address 403 S. WOLFE ST.
19 (a) MAY 4 1945 (Date received by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3-1945 at 2 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1945 to 5-3 1945 and that I last saw h.e.r. alive on 5-3 1945

Immediate cause of death	Duration
Acidosis	1 day
Due to Diarrhea	1 day
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....
23. Signature C. Gauvain Jr. M. D.
Address 7 H H Date signed .....

For A. J. Stritzinger, by Howard D. Thurston, M.D.

VS 150

G28530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D G28530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Hudson Street (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John F. Hatton

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1873

8. AGE: Years 71 | Months 6 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business FOR SELF

FATHER
12. Name George Hatton
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise Hatten
15. Birthplace Baltimore, Md.

16 (a) Informant Agnes Hatton
(b) Address 3024 Hudson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 7 (day) 45 (year)
(c) Cemetery or crematory BALTIMORE
Location END OF E. NORTH AVE.

18 (a) Funeral director Lilly and Gieler Inc.
(b) Address 403 BIDDLE ST.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert A. Gerstenberg M.D. Medical Examiner.
Date signed May 3 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628531 TN. 93427 93427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 628534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6703 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Mack

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd, 1942

8. AGE: Years 3 | Months 0 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Eddie Mack
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Yichler
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 4/45 (month) (day) (year)
(c) Cemetery or crematory OAK HILL
Location PHILA. ROAD

18 (a) Funeral director Lilly and Geiler INC
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd, 1945 19 , at 9.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3rd, 1945 to May 3rd 1945 and that I last saw her alive on May 3rd 19 45

Immediate cause of death — Duration

Due to Meningitis, meningococcic — about 12 hrs

Due to Meningococcemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Burmingham M. D.
Address BCH. Date signed 5-3-45

VS 150 MAY 4 1945 Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

G28532 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Jarowski (JAROWSKI)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Ignatius

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 5/3/1884

8. AGE: Years 60 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Ignatius Sawicki
13. Birthplace Poland

MOTHER
14. Maiden Name Helen Alexiewicz
15. Birthplace Poland

16 (a) Informant Mr. Ignatius Jarowski
(b) Address 2308 E. Baltimore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk.
Location Taylor Avenue

18 (a) Funeral director Mr. F. Sadowski & Sons
(b) Address 1808 Eastern Ave.

19 (a) MAY 4 1945 Huntington Williams, Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1945 at 12:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1945 to 5-2 1945 and that I last saw her alive on 5-2- 1945

Immediate cause of death Hypostatic Pneumonia — Duration 4 Days

Due to General debility

Due to Peritoneal carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-23-45
Major findings of operation: Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald F. Gleason M. D.
Address University Hosp. Date signed 5-2-45

VS 190

G28533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G28533

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 Oella Ave Catonsville (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11-1898

8. AGE: Years 46 | Months 7 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William H Brown
13. Birthplace Md

MOTHER
14. Maiden Name Euphemia Perkins
15. Birthplace Md

16 (a) Informant Christina Brown
(b) Address 338 Oella Ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6-45 (month) (day) (year)
(c) Cemetery or crematory W. Libva Co
Location Baltimore Co

18 (a) Funeral director Sam'l W. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) (Date received by registrar) MAY 1945 (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1945, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1945, to 5-2 1945, and that I last saw h[illegible] alive on 5-2 1945.

Immediate cause of death Cachexia — Duration

Due to Carcinoma of biliary apparatus & Intestines

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/ 1945

Major findings of operation:

Ca of biliary apparatus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M.D.
Address University Hosp Date signed 5/11/45

G28534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G28534 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 George St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto. md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William Taylor
13. Birthplace Norfolk Va.

MOTHER
14. Maiden Name Eunice Tigress
15. Birthplace Macon Ga.

16 (a) Informant Eunice Taylor
(b) Address 802 George st.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 4 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3 1945 at 5:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1-1945 to 5-3-1945, and that I last saw h[illegible] alive on 5-3-1945.

Immediate cause of death	Duration
Premature 7 months	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Consultant Chap Date signed 5/4/45

VS 150

2690

X

628535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 628535

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 S. Bruce St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Davis — 8695

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 2 45

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Sadie
15. Birthplace

16 (a) Informant Hosp Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (MAY 4 1945) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 29 1945, to May 1 1945, and that I last saw h alive on May 1 1945.

Immediate cause of death Pulmonal Hemorrhage — Duration 2 hrs

Due to Premature — Duration 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Mercy Date signed 5-1

VS 150

2689 X

628536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 628536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bandy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/1/45

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Lonie Bandy
13. Birthplace Brunswick, Va.

MOTHER
14. Maiden Name Ruth Rigsby
15. Birthplace Greenbrier Co. W. Va.

16 (a) Informant Mrs. Ruth Bandy
(b) Address Route #1 Aberdeen, Md. Harford Co.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 4 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2/1945, at 12 25/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/1945 to 5/2/1945 and that I last saw him alive on 5/2/1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Intracranial hemorrhage	
Due to	
Other Conditions Prem. abp. placenta, marginal placenta previa (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ward D. Brown-Kelly M.D.
Address University Hospital Date signed 5/4/45

VS 3

2688

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

G28537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G28537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 W. Biddle St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Sidney Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68	?	?	.....hr. .....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a) Burial (b) Date thereof 5/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Int Oakmont
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1945

18 (a) Funeral director.....
(b) Address.....

19 MAY 4 1945 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-45 1945, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945, to April 29 1945 and that I last saw him alive on April 29 1945.

Immediate cause of death Toxemia — Duration .....
Due to Bilateral Miliary Pulmonary Tuberculosis — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature C. W. Jarman M. D.
Address University Hosp. Date signed 4-31-45

vs [illegible] Biddle Hamilton 2687 Jarman

G28538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G28538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen. Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Seaman (b) County S. S. Floyd Gibbons
(c) City or town Pier 8, Port Covington
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alex X. Piatek PIATEK (OR) PIATAK

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife *

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) 8-24-1924

8. AGE: Years 20 | Months 8 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Fair Point, Ohio
(Town, county, and state)

10. Usual Occupation Merchant Seaman

11. Industry or business

FATHER
12. Name Jacob Peartak Piatak
13. Birthplace Poland

MOTHER
14. Maiden Name Anniela Markiawics
15. Birthplace Poland

16 (a) Informant Back Funeral Home
(b) Address St. Clairsville, Ohio

17 (a) Burial, cremation, or removal (b) Date thereof 5-4-45 (month) (day) (year)
(c) Cemetery or crematory
Location St. Clairsville, Ohio

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) 1045 (Entered by registrar) (b) Huntington, West Virginia Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3-45 at 12 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured 1st & 2nd Cervical Vertebrae

Due to

Other Conditions Multiple fractures, lacerations, head bruises - bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-3-45 at 12.30 A M. 23-3
(b) Where did injury occur? Hanover & McComas Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Caussen M.D.
Medical Examiner.

Date signed 5-3-45

(over) X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G28539 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 W. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 W. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** ELLISON SMITH GODWIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Claire K. Godwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1878

8. AGE: Years	Months	Days	If less than one day
66	4	10	hr. min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Consolidate Apts. Corp.

FATHER
12. Name Ellison Godwin
13. Birthplace Va.

MOTHER
14. Maiden Name Indiana James
15. Birthplace Va.

16 (a) Informant Mrs. Claire K. Godwin
(b) Address 101 W. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945, to May 2 1945, and that I last saw him alive on May 2 1945.

Immediate cause of death Acute Dilation Heart. — Duration 48 hours

Due to Occlusion Coronary Arteries

Due to Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Graham Manston M.D.
Address 514 Cathedral St. Date signed 5-3-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G28540 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 George St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) 49

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 George St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Joseph Dungee Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	widowed

6 (b) Name of husband or wife Ella Dungee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1896

8. AGE: Years	Months	Days	If less than one day
49	—	—	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation porter
11. Industry or business fur company
FATHER 12. Name James F. Dungee
FATHER 13. Birthplace Baltimore, Md
MOTHER 14. Maiden Name Hester Nichols
MOTHER 15. Birthplace —
16 (a) Informant Cuvon Dungee
(b) Address 710 Dolphin St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 5 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn A.A.Co. Md.
18 (a) Funeral director Mrs Dola Bailey
(b) Address 1421 E. Jefferson St
MAY 6 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 1:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to May 3 1945, and that I last saw him alive on May 3 1945.

Immediate cause of death	Duration
cerebral hemorrhage	30 minutes
Due to malignant hyper-tension	15 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James B. Carr, M. D.
Address 715 Mulberry St Date signed 5-4-45

VS 3

G28541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G28541

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Kildare Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Kildare Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Angell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or ~~wife~~: Theodore Angell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1865

8. AGE: Years 79 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Alfred Whitmore

13. Birthplace Md.

MOTHER 14. Maiden Name Annie Dewees

15. Birthplace Md

16 (a) Informant Lillie Eicholtz

(b) Address 2819 Kildare Drive

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 5/7/45 (month) (day) (year)

(c) ~~Cemetery or crematory~~ Keysville

Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) MAY 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to May 4 1945 and that I last saw her alive on May 4 1945

Immediate cause of death: Coronary Thrombosis — Duration: 2 days

Due to Arteriio-Sclerotic Cardio Vascular disease

Due to

Other Conditions Diabetes Mellitus — 6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Hammersmith M.D.

Address Balto Md Date signed 5/4/45

VS 150

93D

G28542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered G28542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33 d & Calvert St.

(c) Hospital or institution: Union Memorial Hosp. 9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 33

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1802 E. 31st St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Henry Goddard

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-0819

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Estelle M. Goddard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1890

8. AGE: Years	Months	Days	If less than one day
55	3	24	hr. min.

9. Birthplace New Hampshire (Town, county, and state)

10. Usual Occupation Athletic Director

11. Industry or business Colleges Co.

FATHER 12. Name David Goddard

13. Birthplace Canada

MOTHER 14. Maiden Name Selina Renaud

15. Birthplace Canada

16 (a) Informant Estelle M. Goddard

(b) Address 1802 E. 31st st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 (a) MAY 5 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to May 3 1945 and that I last saw h[illegible] alive on May 3 1945

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Posterior Myocardial Infarction	
Due to Multiple pulmonary Infarctions	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Melchijah Grogins

Address U. M. H. Date signed 5-3-45

G28543
472682.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

G28543
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Mulligan St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Willie May Walton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-21-44

8. AGE: Years | Months: 4 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Alfred Walton
13. Birthplace: Va.

MOTHER
14. Maiden Name: Eva Giles
15. Birthplace: Md

16 (a) Informant: Friends.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory: Aberdeen, Md
Location:

18 (a) Funeral director: Joseph D. Lock Jr
(b) Address: 1324 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams M.D.

VS 150 MAY 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945 at 3. A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to May 3 1945 and that I last saw him alive on May 3 1945:

Immediate cause of death: Bilateral Otitis media, diarrhea, and dehydration and Malnutrition — Duration: appox 3 weeks

Due to: Pneumococcal type 19

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: C. Gowan Jr. M. D.
Address: J HH Date signed 5/4/45

628544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 628544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: JENNIE PHILLIPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Philemon Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1882

8. AGE: Years 62 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Hairdresser

11. Industry or business

FATHER
12. Name William Barney
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Morgan
15. Birthplace Md.

16 (a) Informant Mr. Philemon Phillips
(b) Address 826 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (Registered by registrar) MAY 5 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945 19 , at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1945 to May 3 1945. and that I last saw her alive on May 3 1945.

Immediate cause of death: Cardiac Failure — Duration: 5 days

Due to: Hypertension — Duration: ?

Due to: — Duration: over

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 1631 W Franklin St Date signed 5-4-45

X

G28545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Elmtree ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Elmtree St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** PeTras NAVICITAS

3 (b) If veteran, name war V | 3 (c) Social Security Account No. ?

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant VERONICA RODOWSKI
(b) Address 1640 HAZEL ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anundell County

18 (a) Funeral director Joseph Kasynska
(b) Address 602 Washington Blvd

19 (a) MAY 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 1945 to 1945, and that I last saw h[illegible] alive on Apr 16 1945

	Duration
Immediate cause of death Myocarditis	
Due to Cardiac dilatation	
Due to Arteriosclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Morley Stone M.D.
Address 602 Washington Blvd Date signed 5/4/45

approved by Howard A. Andersen, M.D.

G28546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G28546
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2800 Kennedy Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Kennedy Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth. S. Nolker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry Nolker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/62

8. AGE: Years	Months	Days	If less than one day
83	0-1	30	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Rudolph Kramer
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Matilda Nolker
(b) Address 2800 Kennedy Ave

17 (a) Burial (b) Date thereof 5-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lucas & Sons Funeral Home
(b) Address 7401 Belair Rd.

19 MAY 5 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1945 at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to May 3 1945 and that I last saw h[illegible] alive on May 3 1945

Immediate cause of death	Duration
Hypostatic Congestion & Terminal Pneumonia	
Due to Chronic Myocarditis	
Due to Chronic Nephritis	
Other Conditions Arterio Sclerosis Senile Atrophy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3008 Shannon Drive Date signed 5/4/45

G28547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G28547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Cranston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carmella Sevo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1925

8. AGE: Years	Months	Days	If less than one day
19	9	22	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Sevo
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Minnie Mariglio
15. Birthplace Balto, Md

16 (a) Informant Mazmie Mariglio (Mother)
(b) Address 4009 Cranston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7-1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2413 Greenmount Ave

MAY 5 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to May 4 1945, and that I last saw h.e. alive on May 3 1945

Immediate cause of death Cardiorespiratory death
(Interval)
Due to Leukemia
Due to anemia
Other Conditions
(Include pregnancy within 3 months of death)

Duration 2½-3 yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Palisi M. D.
Address Mercy Hosp Date signed 5/4/45

VS 150

(over)

X

628548

AB98512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

628548
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alois Vondracek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Barbara (Nee Cudlin)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3- 1879

8. AGE: Years 66 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Czechoslavakia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Frank (D)
13. Birthplace Czechoslavakia

MOTHER
14. Maiden Name Katherine (D)
15. Birthplace Czechoslavakia

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Phila. Rd. Balto. Md.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601 E. Madison St. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MAY 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5- 1945, at 1.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26- 1945, to 5-5 1945, and that I last saw h. 1m alive on 5-5- 1945.

Immediate cause of death Cardiac insufficiency — Duration 3 hrs.
Due to arteriosclerotic heart disease — Duration ?
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Date signed 5-5-45

X

G28549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28549 Registered No. 161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen Hosp 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 493 Towne St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Stepo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace South Balto Gen Hosp.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Peter John Stepo
13. Birthplace Balto

MOTHER
14. Maiden Name Genevieve Skowronski
15. Birthplace Balto

16 (a) Informant Mrs Ethel
(b) Address South Balto Gen.

17 (a) Burial (b) Date thereof 5/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ St. Stanislaus
Location Baltimore, Md.
18 (a) Funeral director C. E. Schimunek
(b) Address 2601 E. Madison Street
19 (a) — (b) Huntington Williams, M.D.
(Date filed by registrar) Registrar

MAY 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4-45 19 45, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2-1945 to 5-4-1945 and that I last saw h[illegible] alive on 5-3-1945

Immediate cause of death	Duration
Complete Atelectasis Left Lung (Congenital)	5-2-45
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature C. E. Schimunek
Address 342 E. Eager Ave. Date signed 5-4-45 M. D.

X

628550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

628550
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hours

2. USUAL RESIDENCE OF DECEASED: Harford
(a) State Maryland (b) County Baltimore
(c) City or town Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Archer Blaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith Mullen Blaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1906

8. AGE: Years	Months	Days	If less than one day
38	7 4	5 25	hr. min.

9. Birthplace Street, Baltimore County, Maryland (Town, county, and state)
10. Usual Occupation Store Keeper
11. Industry or business

FATHER
12. Name George Blaney
13. Birthplace Street, Maryland

MOTHER
14. Maiden Name Mabel Taylor
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs Edith Mullen Blaney
(b) Address Street, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1945 (month) (day) (year)
(c) Cemetery or crematory Holly Cross
Location Roland Ave & Underwood Rd

18 (a) Funeral director J. Thomas Duffy
(b) Address Same Place

19 (a) (Date received by Registrar) (b) Registrar

MAY 5 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 8 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945 to May 4 1945 and that I last saw him alive on May 4 1945.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to? Rheumatic Heart Disease?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 5/4/45 M. D.

X

G28551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28551 Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Provident Emergency Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 783 W. Mulberry (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WORSLEY

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1943.

8. AGE: Years 1 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Elwood Carroll
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Margaret Worsley
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Ethel Worsley
(b) Address 783 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Interring for Williams Funeral Home

MAY 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2/45 19 . at 6:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, broncho (Lobar)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 5/7/45

X

G28552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

G28552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 875 W. Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 875 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lizzie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1875

8. AGE: Years	Months	Days	If less than one day
49	9	21	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown.
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Lizzie Smith.
(b) Address 875 W. Fairmount Ave.

17 (a) Burial (b) Date thereof 5-5 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 5 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1945, at 4.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945, to May 2 1945, and that I last saw h[illegible] alive on May 2 1945.

Immediate cause of death Respiratory failure — Duration

Due to Cardiac failure

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. Thorofare
Address 601 N. Broadway Date signed 5/7/45

L. Thorofare

VS 150

G28553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28553 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reuben Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Wilmington N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Moore
13. Birthplace N.C.

MOTHER
14. Maiden Name Josephine St. George
15. Birthplace N.C.

16 (a) Informant Sadie Hart (sister)
(b) Address 2004 - 12th St, Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5, 7, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder Sts.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1945, at 7 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 19/1

(a) Date of injury 5 P.M. at 4-29-45 M.
(b) Where did injury occur? 1705 Pierce St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury fell down stairs.

23. Signature Robert E. Fraim M.D.
Medical Examiner.
Date signed 5-3-45

VS 19 MAY 5 19

Registrar, M.D.

628554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

628554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Bruzinskas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife late John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25th 1889

8. AGE: Years	Months	Days	If less than one day
55	6	9	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name Joseph Aleksa
13. Birthplace Lithuania

MOTHER
14. Maiden Name Gertrude Saukatis
15. Birthplace Lithuania

16 (a) Informant Mrs. Frank J. Bolger
(b) Address 834 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

19 (a) MAY 5 1945 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1945 to May 4 1945 and that I last saw h[illegible] alive on May 2 1945.

Immediate cause of death	Duration
Congestion of all body	
Due to Heart Failure	
Due to Rectal Carcinoma	Heart 2 Months
Other conditions Leucocytosis	

(Include pregnancy within 3 months of death)
Date of operation 3-16-45
Major findings of operation: Malignant
of autopsy: Leucocytosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. S. Marz M. D.
Address 116 Cathedral Date signed 5-5-45

Dup. Balto County
628565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. 628555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 667 Pierce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yr.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 667 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife Alfred Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1899

8. AGE: Years	Months	Days	If less than one day
45	11	3	hr. min.

9. Birthplace Accomac Co. Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name George Custis
13. Birthplace Va

MOTHER
14. Maiden Name Maggie Joynes
15. Birthplace Va

16 (a) Informant Goldie Warner
(b) Address 667 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradley Ave

19 (a) [illegible] 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1945 to 5/2 1945 and that I last saw h[illegible] alive on 5/2 1945

Immediate cause of death Cerebral Hemorrhage
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Woody M. D.
Address 1611 Eutaw Pl Date signed 5-5-45

Approved by Howard D. Woody, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G28556 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Int. Holly St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Int. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John J. Schierlitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Louisine Schierlitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 - 1874

8. AGE: Years	Months	Days	If less than one day
71.	01.	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation City Tax Collector.
11. Industry or business Office

FATHER
12. Name Jacob Schierlitz
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Krebs
15. Birthplace Germany.

16 (a) Informant Mrs. Louisine Schierlitz
(b) Address 2121 Int. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7. 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore

18 (a) Funeral director Jennie Cook Leffler
(b) Address 1600 N. North ave.

19 (a) (Undertaker's registration) (b) MAY 5 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3. 1945 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945 to May 3 1945 that I last saw h. alive on May 3 1945.

Immediate cause of death	Duration
Ventricular Fibrillation	
Due to Coronary Thrombosis	11 Hrs.
Due to Coronary Artery Disease	
Other Conditions Arteriosclerotic C—V. Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Kosman M. D.
Address 4037 Falls Rd. Date signed 5/5/45

X

G28557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G28557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3118 Brighton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Carter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Joseph J. Carter
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Connor
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary A. Matthews
15. Birthplace Md.

16 (a) Informant Mr. Joseph L. Carter
(b) Address 2234 Crest Road

17 (a) Burial (b) Date thereof 5/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 (a) MAY 5 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1945, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1945, to May 4 1945, and that I last saw her alive on May 4, 1945

	Duration
Immediate cause of death Myocardial insufficiency	3 months
Due to arteriosclerotic type heart dis with hypertrophy & dilatation	
Due to failure.	
Other Conditions Generalized arteriosclerosis with hypertension	several years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Mitchell M. D.
Address 2901 Edmondson Ave. Date signed May 5 45

VS 150

X

628558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

628558 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3318 Egerton Road
(c) Hospital or institution:

15-11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Egerton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sada Keen Linthicum

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Mullikin Linthicum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	24	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Littleton Keen
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Sutton
15. Birthplace Md.

16 (a) Informant Mary R. Kenly
(b) Address 407 Hawthorne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery or crematory Grove Cemy.
Location Aberdeen, Md.

18 (a) Funeral director John O. Mitchell Funeral Home Inc.
(b) Address 1900 Eutaw Place

19 MAY 5 1945 (b) (Date rec'd by Reg.) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1945 to May 4 1945, and that I last saw her alive on May 4 1945

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to Arterio sclerotic type heart disease with hypertrophy — Duration Several years

Due to Generalized arteriosclerosis with hypertension — Duration years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Michel M. D.
Address 2901 Edmondson Ave. Date signed May 5 1945

VS 150

G28559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No. G28559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Presbury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Washington

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name Lamabee

15. Birthplace

16 (a) Informant Joseph Washington

(b) Address 1610 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)

(c) Cemetery or crematory Franklin Sq. Location

18 (a) Funeral director Leg. H. Nelson

(b) Address 1303 Preastman St

19 MAY 5 1945 (Date rec'd by registrar) (b) Huntington Wilt Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/45 at 12 35 AM

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh P. McNally M.D. Medical Examiner.

Date signed 5/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G28560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G28560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital 16 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Lawrence St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-5448

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	married

6 (b) Name of husband or wife Rose Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-10

8. AGE: Years	Months	Days	If less than one day
35	2	18	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and State)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Joseph Thomas
13. Birthplace Not known

MOTHER
14. Maiden Name Mamie ?
15. Birthplace Not known

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Leo. B. Kelson
(b) Address 1303 Presstman St

19 MAY 5 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4- 1945, at 1.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1945 to 5-4 1945, and that I last saw him alive on 5-4 1945

Immediate cause of death Ruptured Gastric ulcer — Duration

Due to

Due to

Other Conditions Talon pneumonia
(Include pregnancy within 3 months of death)

Date of operation 4-27-45

Major findings of operation: Ruptured gastric ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Wilson M. D.
Address 803 N. Fremont Date signed 5-5-45

VS 150

G28561 Hewlin

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G28561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Lorman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Lorman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sem S. Hewlin

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/1943

8. AGE: Years 1 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Samuel B. Hewlin
13. Birthplace Md

MOTHER 14. Maiden Name Margaret Shippard
15. Birthplace Md.

16 (a) Informant Margaret Hewlin
(b) Address 1634 Lorman St

17 (a) Burial (b) Date thereof 5/8/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Presstman St

19 (a) MAY 5 1945 (b) Huntington Willcutts, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945, to May 3 1945, and that I last saw h. alive on May 3 1945.

Immediate cause of death Lobar Pneumonia — Duration 3 hr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redden Jr. M.D.
Address 426 N. Gilmor Date signed 5/5/45

TANdy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28562 47758 46B Registered No. G28562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Keyser (If outside city or town limits, write RURAL and give town)
(d) Street No. Blunden Optm (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edwin Tandy.
3 (b) If veteran, name war
3 (c) Social Security Account No. 032-10-6129

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Hannah Tandy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-99

8. AGE: Years	Months	Days	If less than one day
52.	1	10	hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business

FATHER
12. Name P. E. Tandy.
13. Birthplace Ky.

MOTHER
14. Maiden Name Rose. M. Coon.
15. Birthplace Ky.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/5/45 (month) (day) (year)
(c) Cemetery or crematory Remonly
Location Keyser, W. Va

18 (a) Funeral director C. Reilay Slade
(b) Address 4907 York Road

19 (a) MAY 5 1945 (b) Filed by registrar Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 7. P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1945 to May 4 1945 and that I last saw him alive on May 4 1945

Immediate cause of death Postoperative Bronchopneumonia — Duration

Due to

Due to

Other Conditions Cancer of the Stomach

(Include pregnancy within 3 months of death)

Date of operation 4-23-45

Major findings of operation: Extensive carcinoma of the stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunnly M. D.
Address J. H. H. Date signed 5-4-45

VS 150

G28563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

Registered No. G28563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26. 1945

8. AGE: Years 0 | Months 0 | Days 4 5 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Alice E. Grimes
15. Birthplace Unknown

16 (a) Informant Alice E. Grimes
(b) Address 1419 W. Fayette st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5. 1945 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill Cem.
Location Towson Md

18 (a) Funeral director Pratt & B. M. Wallace
(b) Address Pratt & Stricker Sts

19 (a) MAY 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 7 40 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intoxication

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 4 1945

G28564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

Registered No. G28564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218. W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218. W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer C. Newton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-07-9652

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Kelly.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25. 1897

8. AGE: Years 48 | Months - | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name James E. Newton.
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Annie E. Cook.
15. Birthplace Balto Md.

16 (a) Informant James E. Newton
(b) Address 1218 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Thos J. Kenny
(b) Address 1 Elmo & Gilma

MAY 5 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1945, to May 2 1945, and that I last saw h alive on 19

Immediate cause of death Arterio Sclerosis
of Asthenia

Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A Morgan M.D.
Address 716 W Fayette St Date signed May 6 45

VS 180

628565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 20740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eaton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No.: 27 Newburg ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: William Trieschman
3 (b) If veteran, name war:
3 (c) Social Security Account No.: None

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Annie Trieschman
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1870

8. AGE: Years: 75 | Months: 9 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Randallstown, Balto. Co. Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Henry Trieschman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Herbert Trieschman
(b) Address: 6400 Murray Hill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 6, 1945 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cem.
Location: Ellicott City, Md.

18 (a) Funeral director: Easton Home
(b) Address: 608 Frederick Ave Catonsville

19 (a) [illegible] day registered: MAY 5 1945 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/4 1945, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945 to 5/4 1945, and that I last saw h/m alive on 5/4 1945.

Immediate cause of death: Heart Failure (Arteriosclerotic - Hypertensive C.V. disease) — Duration: (?)

Due to: Pulmonary congestion

Due to: Arteriosclerosis, chronic bronchitis

Other Conditions: Gout

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Williams Bryson (M.D. Clerk)
Address: St Agnes Hospt Date signed: 5/7/45

X

VS 150

628566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. 628566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2409 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth E. Jenkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Walter H. Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6-1898.

8. AGE: Years 47 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Virginia.
(Town, county and State)

10. Usual Occupation House Wife.

11. Industry or business at home.

FATHER 12. Name Slaughter Scott.
13. Birthplace Va.

MOTHER 14. Maiden Name Sarah Pitts.
15. Birthplace Va.

16 (a) Informant Miss Elizabeth Davis.
(b) Address 2409 W. Lexington St.

17 (a) Removal. (b) Date thereof May 7-45.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Shiloh Church Cem.
Location King George - Va.

18 (a) Funeral director Charles L. Schwab.
(b) Address 505 N. Monroe St.

MAY 5 1945 (b)
(Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 3rd. 1945, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to May 3 1945, and that I last saw her alive on May 2 1945

Immediate cause of death Uremia

Duration 9 days

Due to Congestive hypostatic arteriolar glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Callahan M. D.

Address 24 W Eutaw Pl Date signed 5/4/45

X

G28567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 B

G28567
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts
(c) Hospital or institution: Univ Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Daughregan Manor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** NORA HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow.

6 (b) Name of husband or wife John Howard. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1882

8. AGE: Years 62 | Months 7 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Joseph Jones.
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-45 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Clarksville Md

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

19 (a) 6 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 5 1945, and that I last saw him alive on May 5 1945.

Immediate cause of death Acute Pericarditis — Duration

Due to Septicemia

Due to Varicose ulcer left leg

Other Conditions Arteriosclerosis generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy: 1. Acute pericarditis (fibrinopurulent) 2. Arteriosclerosis of autopsy: 3. Varicose ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Halges

Address Univ City Hospital Date signed 5/5/45

VS 150

G28568 BALTIMORE CITY HEALTH DEPARTMENT ✓ G28568

CERTIFICATE OF DEATH 131a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2046 N. Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2046 N. Bentalou
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Feinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Gershon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry
13. Birthplace Russia

MOTHER 14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Sam Feinstein (Son)
(b) Address 2046 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-45 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Greendale

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1939 E. Baltimore St

(c) Huntington Williams Mgr (Signature)

19 (a) Date received by registrar 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 1945, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. Hugh B. McNally M.D. Medical Examiner.
Date signed 5/5/45

VS 151

X

G28569

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G28569

Registered No.

CERTIFICATE OF DEATH 117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flint st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard Schaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1869

8. AGE: Years	Months	Days	If less than one day
76	1	6	hr. min.

9. Birthplace Howard Co
(Town, county and state)

10. Usual Occupation Retired B & O

11. Industry or business

FATHER 12. Name Emanuel Schaffer

13. Birthplace Penn

MOTHER 14. Maiden Name Rachael Grimes

15. Birthplace Howard Co

16 (a) Informant James B Schaffer.

(b) Address 601 S Howard St

17 (a) Burial (b) Date thereof May 7-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westerns Mem

Location

18 (a) Funeral director Charles P Powell

(b) 1945 Edmondson Ave

19 (a) (Date rec'd by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 4 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic gastric ulcer, Emaciation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Le Gratten M.D.
Medical Examiner.

Date signed May 4 1945

VS 151

X

correct age is especially important. Physicians: please write the

G28570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G28570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1336 Towson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 Towson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W. Moseley.

3 (b) If veteran, name war WWI.

3 (c) Social Security Account No. 215-01-9703a

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife. Ella Moseley

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 25th 1876

8. AGE: Years 69 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Town, County, and state)

10. Usual Occupation Pile Driver

11. Industry or business pensioned

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ella Moseley
(b) Address 1336 Towson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dill.
(b) Address 1501 E. Fort Ave.

19 (Date rec'd by registrar) MAY 6 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1945, to 5-3 1945, and that I last saw h[illegible] live on 5-3 1945.

	Duration
Immediate cause of death Chronic Myocardial Degeneration	2yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Holland M. D.
Address 707 E. Fort Ave. Date signed 5-4-45

VS 150

G28571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G28571 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 N. Court
(c) Hospital or institution: 51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 N. Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth F Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1878

8. AGE: Years 67 | Months 1 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Scott Ransom
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Georgia Vesar
15. Birthplace N. Carolina

16 (a) Informant James Watkins
(b) Address 1210 N Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott Dft.
(b) Address 129 N. Carolina St.

19 (a) (Date rec'd by registrar) MAY 6 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938, to May 3 1945, and that I last saw h[illegible] alive on May 3 1945.

Immediate cause of death: Cerebral Hemmorhage — Duration: 2 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A Johnson

Address 2309 Kenwood Ave Date signed May 7 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G28572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G28572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Casadel ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Casadel ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gustav Kuwitz

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-07-9538

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Emma A. Kuwitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1880

8. AGE: Years 64 | Months 8 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name unknown Kuwitz
13. Birthplace Latvia

MOTHER
14. Maiden Name Helen Bunte
15. Birthplace Latvia

16 (a) Informant Miss Emelie Kuwitz
(b) Address 1709 Casadel ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) MAY 6 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1945 to May 2 1945, and that I last saw h-- alive on May 1 1945

Immediate cause of death: Carcinoma of lung — Duration: 3 mos

Due to: Cardiac failure

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Lung tumor

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harr McKieffer M. D.
Address 2470 Mast Blvd Date signed 5-3-45

Huntington Williams, M.D.

X

G28573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G28573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 752 E. 30th st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 752 E. 30th st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret RoKosky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband Joseph RoKosky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1904

8. AGE: Years 40 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name John P. Knighton
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Violet St. John
15. Birthplace Washington D.C.

16 (a) Informant Albert F. Hagen
(b) Address 3528 Elmley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery Holy Cross
Location Hartford Rd - Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

6 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 1145 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to May 4 1945 and that I last saw h[illegible] alive on May 2 1945

Immediate cause of death	Duration
Carcinomatosis	
Primary lesion — breast	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Singer M.D.
Address 5062 North ave Date signed 5-5-45 M. D.

X

G28574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G28574 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4510 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Roland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wesley Sanders Hanna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Helen T. R. Hanna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1865

8. AGE: Years	Months	Days	If less than one day
79	6	28	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Insurance

FATHER
12. Name Chas. F. Hanna
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Sanders
15. Birthplace Balto. Md.

16 (a) Informant Virginia H. Williamson
(b) Address 4510 Roland Ave

17 (a) Burial (b) Date thereof 5/7/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 1945 (b) Huntington Williams Registrar
(Registered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1945 to May 4 1945, and that I last saw h[illegible] alive on May 4 1945

Immediate cause of death	Duration
Arteriosclerosis	15 yrs
Myocardial degeneration	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H G Jones M.D.
Address 2818 St Paul Date signed 5/6/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28575 / 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 & Calvert.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 E 35th ST. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME Florence E. ~~Mrs Henry B.~~ Leopold.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Harry B. Leopold

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-7-'87

8. AGE: Years 57 | Months 01 | Days 28. | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name William Hoffman
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ell McKernel
15. Birthplace Ireland

16 (a) Informant Husband
(b) Address 611 E 35th St City

17 (a) Burial (~~cremation, or removal~~) (b) Date thereof 5/8/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 6 1945 (Date rec'd by registrar) (b) .....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5 1945 at 4:15 PM

21. I certify that death occurred on the date above stated: that I attended deceased from 4-23 1945 to 5-5 1945
and that I last saw h[illegible] alive on 5-5 1945.

Immediate cause of death ..... Cardio resp failure
Due to Cerebral infarctions
Due to Pneumonia
Other Conditions Coronary thrombosis

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Paul S. Corant M. D.
Address Union Memorial Hospital Date signed 5-5-45

VS 150

X

G28576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28576 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isabella Kernan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Michael J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2nd 1859

8. AGE: Years 86 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George Achenbach
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Caroline (Unknown)
15. Birthplace Md.

16 (a) Informant Raymond Kernan
(b) Address 1911 E. North Ave

17 (a) Burial (b) Date thereof 5/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to May 4 1945, and that I last saw her alive on May 4 1945

Immediate cause of death	Duration
Cerebral hemorrhage	4½ days
Due to Arteriosclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Silverstein M. D.
Address 1101 N. Charles St Date signed 5-5-45

X

628577

JO #15890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

628577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 -11 - 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) since 1890

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore City Hosp. Infirmary (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Lahey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1867?

8. AGE: Years	Months	Days	If less than one day
69?	2	18	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business

FATHER

12. Name Michael A. Lahey

13. Birthplace Ireland

MOTHER

14. Maiden Name Catherine Burke

15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/37 (month) (day) (year)

(c) Cemetery or crematory Locust Point

Location Hollins Ferry Rd

18 (a) Funeral director John J. Gallagher

(b) Address 1611 Light St

19 (a) MAY 6 1937 (Date rec'd by registrar) (b) Harrington Williams, M.D. Registrar

V2 156

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 2, 1945, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4, 1932, to May 2, 1945, and that I last saw h. im alive on May 2, 1945.

	Duration
Immediate cause of death Cardiac hemorrhage	3 hrs.
Due to Arteriosclerosis	
Due to Hypertension Heart disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. M. Phillips M.D.

Address Balto City Hosp Date signed May 3, 1945

G28578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 28578 ✓ G28578 Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 Lakeview Ave
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Farbman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jean Nee Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 29, 1902

8. AGE: Years 43 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Lumber Business

FATHER
12. Name Harris Farbman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Rosenswog
15. Birthplace Russia

16 (a) Informant Dewey Farbman
(b) Address 2425 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

MAY 7 1945 (a) Date received by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 10.15

20. DATE OF DEATH May 5 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 5 1945, and that I last saw h[illegible] alive on May 5 1945.

	Duration
Immediate cause of death: Coronary thrombosis	2 Hours
Due to: Fire (2)	(2) Hours
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Leet, M.D.
Address Temple Garden Apts Date signed 5-5-45

approved H. J. Mendes, M.D.

628579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. 628572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1937 W. Lafayette ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1937 W. Lafayette ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alston B. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5329

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maggie L. Zucker

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9. 1894

8. AGE: Years 50 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Helper on Truck

11. Industry or business American Stores Co

FATHER
12. Name Herbert L. Miller
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nannie Hurling
15. Birthplace W. Va

16 (a) Informant Mrs. Maggie L. Miller
(b) Address 1937 W. Lafayette ave

17 (a) Removal (b) Date thereof May 6/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Queen Point
Location Keyser West Va.

18 (a) Funeral director Harry H. Wiltshire
(b) Address 4101 E. Monument Ave

19 (a) 1945 Huntington Williams M.D.
(Date) (City or county registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to May 6 1945, and that I last saw h-- alive on May 5 1945.

Immediate cause of death Carcinoma of the Lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oscar J. Hardesty MD
Address 220 Glenburn Ave Date signed 5/6/45
M. D.

X Schochat

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

28550

AB-93333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 28580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 50min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 900 Bevans St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gillard (Twin A)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1945

8. AGE: Years | Months | Days | If less than one day 1 hr. 50 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Durman
13. Birthplace ?

MOTHER
14. Maiden Name Permetta Gillard
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated 9:30 a.m. (Burial, cremation, or removal) (b) Date thereof May 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hosp.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 MAY 7 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945, at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1945 to 4-28 1945 and that I last saw her alive on 4-28 1945.

Immediate cause of death PREMATURITY (

Duration 2 8 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N B Burns Jr, M.D. M.D.
Address Balto City Hosp Date signed 4/30/45

X

G28581

AB-93334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G28581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr-33min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Bevans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gillard (Twin B)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1945

8. AGE: Years	Months	Days	If less than one day
			1 hr. 33 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Durman
13. Birthplace ?

MOTHER
14. Maiden Name Permetta Gillard
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals(Record
(b) Address 4940 Eastern Ave.

17 (a) Cremated 9:30 am (Burial, cremation, or removal) (b) Date thereof May 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cities Hospi
Location 4940 Eastern Avenue.

18 (a) Funeral director
(b) Address

19 (a) MAY 7 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28- 1945 at 9.15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28-45 1945 to 4-28 1945, and that I last saw her alive on 4-28 1945.

Immediate cause of death PREMATURITY (28 wks) — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Peary Jr. M.D. M.D.
Address Balto City Hosp Date signed 5/7/45

X

VS 150

28582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 28582

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kolitis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1899

8. AGE: Years 45 | Months 5 | Days 3 | If less than one day hr. min. 49

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business John Herbert Garage

FATHER
12. Name Vincent Kolitas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Cecelia (unknown)
15. Birthplace Lithuania

16 (a) Informant Mrs. Marie Kolitas
(b) Address 853 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Edmondson Ave

18 (a) Funeral director Wareain Cook Inc
(b) Address 1247 St. Paul Street

19 (a) MAY 7 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 1945 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 5/5/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied ...

G28583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. G28583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31 St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Glenwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Norwood (James N. Norwood)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Anna K. Norwood nee Wolfe
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	8	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer --retired
11. Industry or business Armstrong-Cator Co

FATHER
12. Name Edward Norwood
13. Birthplace Maryland

MOTHER
14. Maiden Name ##### Juliet Hill
15. Birthplace Maryland

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location 1800 Greenmount Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAY 7 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 7:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945 to May 3 1945, and that I last saw him alive on May 3 1945.

	Duration
Immediate cause of death Left lower lobar bronchial pneumonia	3 days
Due to Benign gastric ulcer, post operative resection, and gastro-	Unknown
Due to enterostomy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/26/45

Major findings of operation: gastrojejunostomy; local resection of gastric ulcer.

Findings of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.C. Archer M. D.
Address Baltimore, Md. Date signed 5/4/45

US Marine Hospital

628584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

628584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Cheyenne Ave & Oakland Rd.

(c) Hospital or institution West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1942 Linden Ave - 17 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jennie Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. **AGE:** Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Abraham Kleinowitz

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Morris Goldstein

(b) Address 1842 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)

(c) Cemetery or crematory Mt Lebanon Israel

Location Southern Ave

18 (a) Funeral director Levi Lewis Son

(b) Address 1121 E Baltimore St

19 (Date received by registrar) MAY 7 1945 Chas. T. Williams M.D.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 5/6 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1945 to 5/6 1945, and that I last saw h[illegible] alive on 5/6 1945

Immediate cause of death	Duration
Gangrene Intestine	
Mesenteric Thrombosis or Embolism	5 days
Due to Acute C V D	
auricular fibrillation	
Due to Cardiac Enlargement	
Compensated	
Other Conditions	
Puerperal vaginal hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas J. Taylor M.D.

Address WBGH Date signed 5/6/45

VS 180

X

628585 628585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levan Hospital 15 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4133 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Feldman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-1876

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Anna Feldman
(b) Address 4133 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Wenger Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) Huntington Williams

(Date rec'd by registrar) MAY 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1945, at 8:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/5 1945, to 5/6 1945, and that I last saw him alive on 5/5 1945.

Immediate cause of death Myocardial Insufficiency — Duration

Due to Coronary Occlusion

Due to Hypertension & Cerebral Disease

Other Conditions Pulmonary Edema and Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Simmons M. D.
Address Levan Hospital Date signed 5/6

28586

30 #76855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 6 - 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 E. Church Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Muth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1862

8. AGE: Years 82 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frederick Miller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia Worthen
15. Birthplace Baltimore, Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End of North Ave.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) MAY 7 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945, 19, at 1:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21, 1942 to May 3, 1945, and that I last saw h. in alive on May 3, 1945.

	Duration
Immediate cause of death: Coronary heart failure	6 yrs.
Due to: Hypertension of kidneys. Vascular disease	?
Due to	
Other Conditions: Generalized arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Hullings, M.D.
Address Baltimore, Md. Date signed 5-4-45

628587.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

V. 628587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S. Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William J. Spriggs - Nash

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Annie Kelly Nash

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	22	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William Spriggs
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Thomas
15. Birthplace Md.

16 (a) Informant Mrs. Emma Stine
(b) Address 1456 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Henry Sons
(b) Address 714 Light St

19 (a) (Date rec'd by registrar) (b) Huntington, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1945, at 6 yr. AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1945, to 5/4/45 1945, and that I last saw h.i.m. alive on 19

Immediate cause of death Pneumonia, Staph Aureus
2 Mitral insufficiency, rheum.

Duration
7 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar F. Miller, M.D.
Address 2628 Washington Blvd Date signed 5/4/45

VS 150

628588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

628588 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3617 Crossland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Crossland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY M. PRICE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Caroline S. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John G. Price
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna N. Price
15. Birthplace Toronto, Can.

16 (a) Informant Mrs. Anna Y. Weaver
(b) Address 3617 Crossland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MAY 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1945 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16- 1945 to May 3- 1945 and that I last saw him alive on May 3- 1945

Immediate cause of death	Duration
Cardiac decompensation, Heart	2 yrs
Chronic Myocarditis - Heart	5 yrs.
Due to Excessive use of tobacco cigarettes & smoke changes	
Due to	
Other Conditions chronic Bronchitis	15 to 20 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Riemer M. D.
Address 2135 Maryland Ave. Date signed 5/5/45

628589 ✓ 628589

AB 93453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs- 30min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elzina Marie Talbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23- 1933

8. AGE: Years	Months	Days	If less than one day
11	4	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Horace Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Talbott
15. Birthplace Md.

16 (a) Informant BaltimoreCity Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah J Burns & Son
(b) Address 108 W Montgomery St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4- 19 45 at 4.40pM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4- 1945, to 5-4 1945, and that I last saw h or alive on 5-4-45 19 45

Immediate cause of death — Duration

Meningetis probably due to ? anaerobic strep brain abscess — less than 1 wk

Due to

Due to

Other Conditions chronic sup. otitis media, left

Date of operation

Major findings of operation:

of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Brannigham M. D.
Address BCH Date signed 5-4-45

VS 180 Subject to Approval of Medical Examiner 81a

628590 BALTIMORE CITY HEALTH DEPARTMENT 628590

CERTIFICATE OF DEATH 46D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County ?
(c) City or town Xenia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 East 2nd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mrs. Anita Astor Lowry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Major Edward Lowry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-1898

8. AGE: Years	Months	Days	If less than one day
47	2	27	hr. min.

9. Birthplace Iowa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr W.P. Woodcock
13. Birthplace ? Va.

MOTHER
14. Maiden Name Adelaide Tracey
15. Birthplace ? Iowa

16 (a) Informant Hosp Record
(b) Address

17 (a) Removal (b) Date thereof May 8 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ National
Location Arlington Va.

18 (a) Funeral director Kelly N. Jenkins Sons
(b) Address McCulloh & Orchard Sts

19 (a) MAY 7 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/45, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20/45 to 5/5/45
and that I last saw her alive on 5/5/45

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Generalized Carcinomatosis secondary to Ca of rectum	
Due to Malplacement of liver & marked ascites.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M. D.
Address Date signed 5/6/45

VS 150

X

628591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

628591 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. Bay St (Rear)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Eaton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-1980

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49	—	—	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Veterans Administration
(b) Address 315 St Paul St. 5-7-45

17 (a) Burial in Baltimore City (b) Date thereof 5-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat.
Location Frederick Ave Ext.

18 (a) Funeral director Lee Adler
(b) Address 4644 York Rd.

19 (a) MAY 7 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 7:40 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 5-3-45

G28592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G28592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 175 Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 175 S Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederika Redmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband ~~or wife~~ Edward Redmann

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1, 1859

8. AGE: Years 85 Months 10 Days 21 If less than one day hr. min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Charles M. Childs
(b) Address 175 S Linwood Ave.

17 (a) Burial (b) Date thereof 5-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave

18 (a) Funeral director Wendel E Humphreys
(b) Address 1501 N Broadway

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 7

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to May 3 1945; and that I last saw h[illegible] alive on May 3 1945.

Immediate cause of death Acute Cardiac Failure — Duration 2 days

Due to Senile Dementia — 6 mos

Due to Arteriosclerosis — 5 yrs.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Abrams
Address 360 Eastern Place Date signed 5/5/45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

628593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 628593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3024 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Wojtkowiak

3 (b) If veteran, name war: -

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69	-	—	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Wojtkowiak
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant John Wojtkowiak
(b) Address 27 N Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore

18 (a) Funeral director Fred W Ozog zewski
(b) Address 1930 Eastend Ave

19 (a) Filed by (b) Registrar

MAY 7 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1945 to 5/6 1945 and that I last saw h[illegible] alive on 5/3 1945.

Immediate cause of death: Cardiac Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 Hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter F. Kaufmann M. D.

Address 1076 S. East Ave Date signed 5/7/45

628594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

628594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 S. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Dolowski

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Maker

11. Industry or business

FATHER
12. Name Kempf
13. Birthplace Germany ?

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Frank Dolowski
(b) Address 621 S Dallas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/45 (month) (day) (year)
(c) Cemetery or crematory Swartz
Location Baltimore

18 (a) Funeral director Fred W Ozazguski
(b) Address 1930 Eastern Ave

19 (a) MAY 7 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945 at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1945 to May 6 1945 and that I last saw her alive on May 5 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: acute

Due to: Cerebral arteriosclerosis — Duration: ?

Due to: Chr Endocarditis — Duration: ?

Other Conditions — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J Douglas M.D.
Address 708 N Howard St Date signed 5/7/45

X

628595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

628595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Payson Court Dukeland St.

(c) Hospital or institution: West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1834 W. North Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Clara Ernstberger

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry D. Ernstberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	11	hr. min.

9. Birthplace Fisherville, Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name - Lentz

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Mr. Henry D. Ernstberger

(b) Address 1834 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/45 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) MAY 7 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945 to 5/6 1945, and that I last saw her alive on 5/6 1945.

Immediate cause of death Coronary Thrombosis

Due to Coronary Artery Disease Arteriosclerotic CVD

Due to Cardiac enlargement

Due to decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irving J. Taylor M.D.

Address 1136 Eutaw Pl. Date signed 5/6/45

X

528596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. 528596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Tyrone Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Marshall Noakes

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-1555

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary F. Noakes

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 18, 1901

8. AGE: Years 44 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Representative of the

11. Industry or business Commercial Credit Co.

FATHER
12. Name Thomas A. Noakes
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Rhodes
15. Birthplace Maryland

16 (a) Informant Mrs. Mary F. Noakes
(b) Address 218 N. Tyrone Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/8/45 (month) (day) (year)

(c) Cemetery or crematory
Location Pineville, Ky.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 7 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to May 6 1945, and that I last saw him alive on May 6 1945.

Immediate cause of death: Cardio-Resp. Failure — Duration:

Due to: Malignant Lymphoma of mediastinum, type undetermined

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchizedek Sprogues M.D.
Address U.M.H. Date signed 5-6-45

G28597

349956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 E

Registered No. G28592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County.....
(c) City or town Johnstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Locust St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Gary George Matter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-1-41

8. AGE: Years 4 | Months 4 | Days 5 | If less than one day .....hr. .....min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name William H. Matter
13. Birthplace Pa.

MOTHER
14. Maiden Name Vera Matter
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 5/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Johnstown, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 7 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 6 - 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24- 1945 to 5-6- 1945 and that I last saw her alive on 5-6- 1945

	Duration
Immediate cause of death: Cerebral Thrombosis?	
Due to: Anoxia & Hemoconcentration	
Due to: Tetrology of Fallot	
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation 5-5-45

Major findings of operation: Tetrology of Fallot

of autopsy: Tetrology (sustained)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature George Burnich M.D.
Address J. H. H. Date signed 5-6-45

HARPER

628598

628598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

Every item of information should be carefully supplied; please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Sudbrook Lane, Pikesville Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sally E. Harper

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1870

8. AGE: Years	Months	Days	If less than one day
75	0	3	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Marshall Evans
13. Birthplace W. Va.

MOTHER
14. Maiden Name Sally S. Dodd
15. Birthplace W. Va.

16 (a) Informant Mrs. Norman Gattlon
(b) Address 112 Sudbrook La. - Pikesville, Md.

17 (a) Burial (b) Date thereof 5/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Loving Byers
(b) Address 5205 Park Heights Ave

19 (a) (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

MAY 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 5:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to May 5 1945 and that I last saw her alive on May 5 1945

Immediate cause of death	Duration
Cerebro-Vascular accident	
Due to Hypertensive Cardio Vascular disease:	
Due to	
Other Conditions Bronchial asthma, Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Address Md. Gen'l Hospital Date signed 5/5/45

93 D

G28599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G28599

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 406 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Minch.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Ann Minch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1868

8. AGE: Years	Months	Days	If less than one day
77	11	18	hr. min.

9. Birthplace Balto. (town, county, and state)
10. Usual Occupation Police (Retired)
11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Ann Minch
(b) Address 406 N Collington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Ulman Funeral Home
(b) Address 200 Orleans St

19 (a) MAY 7 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 1945, at 11 45 AM

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D. Medical Examiner.
Date signed 5/6/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628600 CWK-88658

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 628600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 10- 12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Orrbright,

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ruth Orrbright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1872

8. AGE: Years	Months	Days	If less than one day
73	2	23	hr. min.

9. Birthplace Alabama
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Mitchell Orrbright
13. Birthplace Alabama

MOTHER
14. Maiden Name Mandy Snowden
15. Birthplace ? Alabama

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.
18 (a) Funeral director Charles S. Cupper
(b) Address 812 W. Carrollton Ave.
19 (a) (b) Huntington Williams, M.D.
Date rec'd by Registrar MAY 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 5 PM M
21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1944, to May 4 1945, and that I last saw h im alive on May 4 1945.

Immediate cause of death	Duration
Cerebral hemorrhage. ?	2 days
Due to Hypertension and Heart disease	
Due to	
Other Conditions Broncho pneumonia, Bronchitis and Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above. Had Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. M. Williams M.D.
Address Balto. City Hosp. Date signed 5-8-45

G28601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G28601 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo & 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Gentry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles L. Gentry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun 16, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Lancelot Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name Mc Brady
15. Birthplace Dist Columbia

16 (a) Informant Mrs Ida L. Kiefer
(b) Address 3962 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Co. Md

18 (a) Funeral director A. Howard Eckert
(b) Address 1400 E. Baltimore St

19 (a) MAY 10 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6-1945, at 2:35 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Fractured femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 23/1

(a) Date of injury 12-9-44 at 8 P. M.
(b) Where did injury occur? Hanover & Clements
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by automobile - Pedestrian

23. Signature Howard J. Wooden M.D. Medical Examiner
Date signed 5-6-45

G28602 BALTIMORE CITY HEALTH DEPARTMENT G28602

CERTIFICATE OF DEATH 331 Registered No.

The ... every item of information should be carefully supplied, WITH UNFADING INK. Every item is especially important. Physicians: please write the correct age to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie L. Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Late Wm T.E. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21, 1869

8. AGE: Years	Months	Days	If less than one day
75	4	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Harry L. Newport
13. Birthplace Maryland.

MOTHER
14. Maiden Name Annie Lippy
15. Birthplace Maryland

16 (a) Informant Mrs. Anna Mae Barnes
(b) Address 1006 Wett Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) MAY 7 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940 to May 4 1945, and that I last saw h alive on 5-4- 1945

	Duration
Immediate cause of death Bronchopneumonia	3 days
Due to Influenza	3 days
Due to	
Other Conditions Obesity	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas H. Kreuter M.D.
Address 524 S. Fulton Ave Date signed 5-5-45

Notified for Williams, M.E.

G28603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G28603

10 #92478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Curry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Steven Curry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ?-1881 ?

8. AGE: Years 53 ? | Months 0 | Days ? | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Waters (d)
13. Birthplace Md.

MOTHER 14. Maiden Name Liza Stanley (d)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location [illegible]

18 (a) Funeral director Robert E. Wilder
(b) Address 615 McElderry St.

19 (a) MAY 7 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1945, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1945, to 5-4 1945, and that I last saw h or alive on 5-4 1945.

Immediate cause of death: Carhepia — Duration: 1 Week?

Due to: Carcinoma of Uterus with metastasis — Duration: 1 Week?

Due to: — Duration:

Other Conditions: — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of left [illegible]

22. Death was due to external causes (violence) as the result of the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hauck E. Dalton
Address Baltimore City Hosp. Date signed 5-7-45 M D

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

628604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

628604 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3417 Brendan Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 Brendan Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CASPER KENTNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	220-01-3305

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Margaret C. Kentner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 11, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business Merchants & Miners

FATHER
12. Name John Kentner
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Mr. Henry C. Kentner
(b) Address 3417 Brendan Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAY 7 1945 (Date rec'd by Local Reg'r) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 12.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1945, to May 4 1945 and that I last saw him alive on May 3 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Cardio-vascular disease	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Z. Stevens M.D.
Address 3400 Eastern Ave. Date signed 5/4/45.

VS 180

6-28605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 6-28605

Please write the causes of death clearly and legibly. Physicians: please write correct age if especially important. Any supplementary information may be given on reverse side.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Dont

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 5931 Bel Air Road (If rural give location)
(d) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY G. HARMON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Velma

6 (c) If alive, give age 1901

7. Birth date of deceased (mo., day, yr.) Nov. 26 - 1897

8. AGE: Years 43 | Months 5 | Days 10 | If less than one day ____hr. ____min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Bethlehem Fairfield

FATHER
12. Name Henry H Harmon
13. Birthplace Alabama

MOTHER
14. Maiden Name Ida Ford
15. Birthplace Alabama

16 (a) Informant Robert E Harmon
(b) Address 5931 Belair Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 7-45 (month) (day) (year)
(c) Cemetery or crematory Birmingham Ala
Location Birmingham Ala

18 (a) Funeral director Wiseman Cook Inc
(b) Address 127 St Paul Street

19 (a) MAY 7 1945 (Date rec'd by Registrar) (b) Hunting for Hilliard M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/45 19____, at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2-3° Burns

Due to

Other Conditions Alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/6/45 at 6:00 P.M. M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell Fireplace Smoking

23. Signature John C. Davis, M.D. Medical Examiner.
Date signed 5/7/45

Coroner 5/7/45 X

628606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

628606 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 N. Durham st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Durham st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Edward Scott

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-3643

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Janie Elizabeth Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1891

8. AGE: Years 54 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Hampton Coal Co

FATHER 12. Name Wesley Scott
13. Birthplace Md.

MOTHER 14. Maiden Name Georgana ?
15. Birthplace Md.

16 (a) Informant Janie Elizabeth Scott
(b) Address 220 n. Durham st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/45 (month) (day) (year)

(c) Cemetery or crematory Arlington Mem. Pk
Location Elroy O Wilson

18 (a) Funeral director 1600 Brant Ave
(b) Address Huntington Wva

19 MAY 7 1945 (Date rec'd by registrar) (c) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 1945, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1944, to 5/3 1945, and that I last saw h/M alive on 5/1 1945.

Immediate cause of death Hypertensive cardio-renal disease

Due to (Cerebral hemorrhage)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne

Address 1500 E. Madison St Date signed 5/3/45

Rayner Browne X

628607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

628607 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. N
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Ellsworth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Kraft

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Robt. Kraft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1880

8. AGE: Years 65 | Months 0 | Days 29 (If less than one day) hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name - - Berlin
13. Birthplace Balto Md

MOTHER
14. Maiden Name -
15. Birthplace Balto Md

16 (a) Informant Mrs Jno Kraft.
(b) Address 1907 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Philip Stanuiszkis Sons
(b) Address 2024 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 1945 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1945 to 5/4 1945
and that I last saw her alive on 5/4 1945

Immediate cause of death Uremia

Duration

Due to sclerochoroiditis

Due to

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: 5/4/45 Large gall stone. Edematous Kidneys

PHYSICIAN
Underline the cause to which death should be charged; statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Otto R. Ewing
Address Univ. Hosp. Date signed M. D. 5/4/45

X

628608

BALTIMORE CITY HEALTH DEPARTMENT 628608

CERTIFICATE OF DEATH 1218

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Southern Ave #14 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Feinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Wh

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Harry H. Feinberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13 1895

8. AGE: Years 50 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Orange Va. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Ames Cove
13. Birthplace Va

MOTHER
14. Maiden Name Florence Carpenter
15. Birthplace Va.

16 (a) Informant Mr Harry H. Feinberg
(b) Address 2903 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8, 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director L. L. Rick
(b) Address 2305 Huntington Ave

19 (a) 1945 (To be filled in by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1945 to 5-5 1945; and that I last saw her alive on 5-5 1945

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Jewish Mem. Hospital Date signed 5-8-45

Except age is especially important. Physicians: please write the causes of death clearly and legibly.

G28609

CWK-93198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G28609

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 Garrett Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John X. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Martha X. ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1853 ?

8. AGE: Years 91 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ??

MOTHER
14. Maiden Name ??
15. Birthplace ??

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 5-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland PK.
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5805 Harford Road

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH May 5 1945, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1945 to May 5 1945, and that I last saw h im alive on May 5 1945.

Immediate cause of death Bronchopneumonia — Duration 7 Days

Due to Cerebral Arteriosclerosis

Due to

Other Conditions Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Baltimore Md. Date signed 5-12-45

7 1945

Huntington Williams, M.D.

VS 150

628610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 628610

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Phillip Braxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace..... (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL MAY 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 MAY 7 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 10:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from; natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic glandular Tuberculosis

(NOTE - TRANSCRIBE CAUSE OF DEATH AS SHOWN ON REVERSE SIDE)

Due to .....

Other Conditions { Cancer of Bladder; Syphilitic Aortitis; Rheumatic Endocarditis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed 4-26-45

F-3094

G28611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164C

Registered No. G28611

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 S. Paca St. - 3rd floor
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles F. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife.....

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
19			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL MAY 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 7 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1-1945; at 10-15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot of Brain

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-1-1945 at ..... P. M.
(b) Where did injury occur? 533 S. Paca St -
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm

23. Signature Howard J. Williams M.D.
Medical Examiner.

Date signed 5-2-45

2093 X

G28612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28612

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Res.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Linden Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles E. Mitchell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
32			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL MAY 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) MAY 7 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH April 29 1945; at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebellar Hemorrhage, spontaneous

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Grayson M.D.
Medical Examiner.
Date signed April 30 1945

VS 151

2692

G28613 G28613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 52B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 S. Brickland St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 S. Brickland St.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME James Simmons

3 (b) If veteran; name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Florence Schuman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1883.

8. AGE: Years	Months	Days	If less than one day
61	8	18	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER 12. Name Francis Simmons
13. Birthplace Md. Western

MOTHER 14. Maiden Name Josephine Conte
15. Birthplace Md.

16 (a) Informant family
(b) Address 134 S. Brickland St

17 (a) ..... (b) Date thereof 5-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director Jesse L. McCauley
(b) Address 1308 E. Fort Ave.

19 (a) MAY 7 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1945, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/1944 to May 5 1945, and that I last saw him alive on 5/4/1945.

Immediate cause of death Carcinoma of bladder

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Harry Deibel M.D.
M. D.
Address 1226 Hanover St Date signed 5/6/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 a

G28614
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Keene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	22	hr. min.

9. Birthplace Cambridge Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Keene
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Manoke
15. Birthplace Md.

16 (a) Informant William J. Keene
(b) Address 1517 E. Preston St.

17 (a) Burial (b) Date thereof May 8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs. Rosalie A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) MAY 7 1945 (b)
(Date received by Registrar) Registrar

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 45, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 25 19 45, to May 4 19 45,
and that I last saw h alive on May 1 19 45.

Immediate cause of death
Uremia
Due to Hypertension
and Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Years
Months
Days
Hours
Minutes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lorenzo T. Quilen
Address 4846 Reisterstown Rd. Date signed 5/9/45

VS 150

X

AB-93342 628615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

Registered No. 628615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Pendle Ct-Zone 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Malette

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6- 1913

8. AGE: Years	Months	Days	If less than one day
31	5	28	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Malette (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Lillie Hopkins (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/45 (month) (day) (year)
(c) Cemetery or crematory
Location Durham, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1008 Brantley ave

19 (a) (Date rec'd by registrar) (b) Washington Williams M.D. Resident?

MAY 7 1945

VS-130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 9.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28- 1945 to 5-4- 1945, and that I last saw h im alive on 5-4- 1945.

Immediate cause of death: Cardiac failure — Duration: 2 months

Due to: Luetic heart disease — 4 yrs

Due to: Coronary occlusion ? — 30 mins

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 5-7-45

X

628616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

628616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 - Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Douglas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Hattie Douglas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-18.

8. AGE: Years	Months	Days	If less than one day
27	2	1	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Jefferson Douglas
13. Birthplace S.C.

MOTHER
14. Maiden Name Clara McRae
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof 5/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Beverly Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 7 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1945, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1945 to 5-6 1945, and that I last saw h[illegible] alive on 5-6 1945.

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to Pulmonary tuberculosis	
Due to Tuberculous adenitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Nature of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital 5/4/45

X

628617
46622

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52 B

Registered No. 628617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct. age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Dayton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Wisconsin Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann. Leopret.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Leon.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 6-22-94

8. AGE: Years 50 | Months 10 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Ohio.
(Town, county, and state)

10. Usual Occupation Home. wife

11. Industry or business

FATHER
12. Name John Molen
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ryan.
15. Birthplace Ireland

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 5/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery crematory Dayton
Location Ohio

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Pearl St.

19 (a) 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 10.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1945, to May 6 1945, and that I last saw h.. alive on May 6 1945

Immediate cause of death: Renal Insufficiency — Duration: 1 wk.
Due to: Carcinoma of — 1 yr.
Due to: Bladder
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature Geo. W. Strong M.D.
Address J. W. Strong. Date signed M. D. 5/7/45

VS 150

628618

BALTIMORE CITY HEALTH DEPARTMENT ✓ 628618

CERTIFICATE OF DEATH 124 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 S. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand F. Denhard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Christine Deahard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 20th - 1873

8. AGE: Years	Months	Days	If less than one day
71	10 9	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Lawyer

FATHER
12. Name Adam Denhard
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Boss
15. Birthplace Germany

16 (a) Informant Louise Denhard
(b) Address 619 S. Ellwood Ave

17 (a) Burial (b) Date thereof 5/9/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] (Huntington for Williams, Mgr.)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17/1945 to 5/5/1945, and that I last saw him alive on 5/5/1945.

Immediate cause of death Cardio-Resp. failure — Duration

Due to Cardiac Decompensation, Bronchopneumonia, Arter.

Due to

Other Conditions? Partial Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley M. Steinberg, M.D.
Address Sinai Hospital Date signed 5/7/45

X

628619 CWK-93193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

628619 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs. 6 mos. 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 208 W. 27th Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Joseph Dwyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4-1861

8. AGE: Years 83 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ~~Dwyer~~

11. Industry or business

FATHER 12. Name William Dwyer (D)

13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Combe (D)

15. Birthplace Maryland

16 (a) Informant Vera Anderson

(b) Address 3904 - 5th St. Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 (Date rec'd by registrar) (b) Burying for Williams M.E. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1945 to May 5 1945, and that I last saw him alive on May 5 1945.

Immediate cause of death: Acute Cardiac Failure — Duration 1hr

Due to Hypertensive Cardio vascular disease & arteriosclerosis — 7

Due to

Other Conditions Benign Prostatic Hypertrophy — 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. J. Penny M.D.

Address Baltimore City Hospitals Date signed 5-6-45

M. D.

628620

AB- 92996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

628620

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30days

(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 405 Markland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer Fowble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9- 1886

8. AGE: Years	Months	Days	If less than one day
58	6	28	hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation City Street Cleaning Dept.

11. Industry or business

FATHER

12. Name John Fowble (D)

13. Birthplace Germany

MOTHER

14. Maiden Name Ellen Tony (D)

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)

(c) Cemetery Black Rock

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1219 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7- 1945 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7- 1945 to 5-7- 1945, and that I last saw him alive on 5-7- 1945

Immediate cause of death Coma Alexandria.

Due to

Due to

Other Conditions Heart failure. Arteriosclerotic heart disease.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

Duration
2 days
T

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. M. Phillips

Address Balt City Hosp Date signed 5-7-45 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

G28621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157

G28621 Registered No.

JO #93168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Decatur St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michele Hornick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1944

8. AGE: Years	Months	Days	If less than one day
-1-	-0-	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Md.

MOTHER
14. Maiden Name Adelaide Holley
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Chas. F. Dill
(b) Address 1521 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1945, at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 17, 1945 to May 5, 1945, and that I last saw h. or alive on May 4, 1945

Immediate cause of death: Pneumonia — Duration: about 5 days

Due to: Microcephaly — Duration: birth

Other Conditions: sclerodema

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Cunningham M. D.
Address BCH Date signed 5-5

VS 150

628622 BALTIMORE CITY HEALTH DEPARTMENT 628622
CERTIFICATE OF DEATH 164C
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4227 Liberty Avenue
(c) Hospital or institution St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4227 Liberty Avenue (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER NEWTON REINSMITH

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ? Marguerite
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1908

8. AGE: Years 37 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Freeland, Pa. (Town, county, and state)
10. Usual Occupation Leader
11. Industry or business Bethlehem Fairfield

FATHER
12. Name Oliver Reinsmith
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Miller
15. Birthplace Upper Lehigh, Pa.

16 (a) Informant Wife
(b) Address 4227 Linwell ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)
(c) Cemetery or crematory Freeland Mem.
Location Freeland, Pa.

18 (a) Funeral director Charles L. Giles
(b) Address 3605 Fait Ave.

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/45 19 , at 6:07 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rifle shot wound of Epigastric Region

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/6/45 at M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Rifle Shot wound

23. Signature John R. Davis M.D. Medical Examiner
Date signed 5/7/45

VS 151

Instructions: Please write the causes of death clearly and legibly. Accuracy is especially important. Physicians: please write the c

628623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

628623 10

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wayford Road
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Alricanna Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Childers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1939

8. AGE: Years	Months	Days	If less than one day
6	4	2	hr. min.

9. Birthplace Cassity, — W. Virginia
(Town, county, and state)

10. Usual Occupation school

11. Industry or business

FATHER
12. Name Harry Childers
13. Birthplace unknown

MOTHER
14. Maiden Name Louise Reader
15. Birthplace Cassity W. Virginia

16 (a) Informant Mrs. Harry Childers
(b) Address 1531 Alricanna Street

17 (a) Burial (b) Date thereof 5-8-45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz's Lane
Location O'Donnell St.

18 (a) Funeral director L. Heermann & Son.
(b) Address 325 S. Broadway.

19 (a) 5/8/45 (b) Registrar
(Date filed) (month) (day) (year)
Herrington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1945 to May 5 1945 and that I last saw him alive on May 5 1945

Immediate cause of death	Duration
Cardiac failure	3 days
Due to Diphtheria myocarditis	1 week
Due to Diphtheria (virulent)	15 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp. Date signed 5-5-45

G28624 ✓ G28624

CWK-30590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 2- 29
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Witt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Frank Witt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12-1870

8. AGE: Years 75 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charlie (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Hertch (D)
15. Birthplace Europe

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8, 45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Chapel St. & Reisterstown Rd

18 (a) Funeral director J. J. Reynolds & Son
(b) Address 32 S. Broadway

19 (a) 5/8/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1945 to May 4 1945, and that I last saw her alive on May 4 1945.

Immediate cause of death Cerebral hemorrhage — Duration 24 hrs.

Due to arteriosclerosis & hypertension and heart failure — Duration ?

Due to — Duration

Other Conditions Diabetes Mellitus — Duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: On affdt.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. M. Hall, M.D.
Address Baltimore, Md. Date signed 5-8-45

Huntington Williams, M.D.

VS 150

937

G28625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1643

Registered No. G28625

Please write plainly with pen or pencil and make no erasures. Be sure that the cause of death is clearly and legibly stated.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Larkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William —
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannora Sullivan
15. Birthplace Ireland

16 (a) Informant Mrs. Elizabeth Franz.
(b) Address 2407 Christian St

17 (a) Burial (b) Date thereof 5.8.45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3500 old Frederick Rd

18 (a) Funeral director Harry A. Wetzel
(b) Address 4101 E Monument Ave

19 (a) MAY 8 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 10 30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions Mental Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 5 at 1945 9 A M.
(b) Where did injury occur? Harbor at Annapolis Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped Off Three Cent Bridge

23. Signature Roscoe Lee Fratson M.D.
Medical Examiner.
Date signed May 7 1945

VS 151

G28626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G28626

Every item of information should be carefully answered. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos, 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto. 14, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Batoma Ave. Batoma
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George A. Johnson

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Mary Johnson
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 6/8/88
8. AGE: Years 56 | Months 10 | Days 29 | If less than one day ... hr. ... min.
9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Mr. Angelo Johnson
13. Birthplace Greece

MOTHER
14. Maiden Name Margaret O'Brien
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Johnson
(b) Address 3310 Batoma Ave
17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 5/10/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1219 St. Paul St
19 (a) MAY 8 1945 (Date rec'd by registrar) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1945 at 6:35 AM
21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19..., and that I last saw h~~im~~ alive on 5/6 1945.

	Duration
Immediate cause of death Respiratory failure,	
Due to Possible primary carcinoma of lung;	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. C. Jenkins M.D.
Address Mercy Hosp. - Calvert & Saratoga Sts. Date signed 5/9/45

VS 150

628627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 628627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1252 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Patricia Adam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-45

8. AGE: Years	Months	Days	If less than one day
0	0	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Charles Adam
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Josephine Frances O'Neill
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.R.Co.

18 (a) Funeral director Rita Windefeld
(b) Address 914 Drummond Ave

19 MAY 8 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 11.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1945 to May 6 1945, and that I last saw h.r. alive on May 6 1945.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Morgal Sepsis	
Due to Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchijah Scagnetti M.D.
Address UMH Date signed 5-7-45

VS 150

628628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

628628 ✓ 940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 N. Franklin Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 N. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelius T. Bowie

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie Bowie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1882

8. AGE: Years	Months	Days	If less than one day
62 63	7	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business City Hall

FATHER
12. Name Reginald N. Bowie
13. Birthplace Md

MOTHER
14. Maiden Name Blanche L. Bouch
15. Birthplace Md

16 (a) Informant Mrs. C. T. Bowie
(b) Address 2702 N. Franklin St

17 (a) Burial (b) Date thereof 5-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Bayview Md

18 (a) Funeral director George G. Fahey
(b) Address Fulton & Fayette Sts

19 (a) (b)
(Date rec'd by registrar) Registrar
Valid MAY 8 1945 Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6-1945, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5-6-45

628629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

628629 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 N. Appleton St.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES W. AUSTEN

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 213-17-0051

4. Sex: MALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida E. Austen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22. 1887

8. AGE: Years 58 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace BALTIMORE Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Wm C. Austen

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Frances D. Bratten

15. Birthplace N. Carolina

16 (a) Informant Thelma V. Presson

(b) Address 315 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director C. & B. M. Walters

(b) Address Park & Stricker Sts

19 (a) (Date rec'd by registrar) (b) Williams M.R. (Signature of registrar)

MAY 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 7:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 26 1945 to May 6 1945 and that I last saw him alive on May 6 1945

Immediate cause of death: Odema of Lungs — Duration: 2 days

Due to: Bronchial Asthma — 4 yrs.

Due to: Acute Myocarditis — 1 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Lichtenberg M.D.

Address 2 W Madison Ave Date signed 5/7/45

X

G28630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G28630 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Lisk Ave
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Lisk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna E. Borghese

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1890

8. AGE: Years	Months	Days	If less than one day
54	5	21	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William F. Meyers
13. Birthplace Md

MOTHER
14. Maiden Name Mary Clady
15. Birthplace Md

16 (a) Informant Mr. Charles Borghese
(b) Address 2703 Lisk Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1945 (month) (day) (year)
(c) Cemetery or crematory Loreland Park
Location Baltimore

18 (a) Funeral director L. J. Burk
(b) Address 5 Tombardy

19 (a) MAY 8 1945 (b) (Date rec'd by registrar) Registrar

Huntington Hillsboro, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 at 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1944 to May 5 1945 and that I last saw h[illegible] alive on May 5 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 7 mos.
Due to —
Due to —
Other Conditions Diabetes Mellitus — 4 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature [illegible]
Address 628 Harford Rd Date signed 5/7/45 M. D.

83a

G28631
JL - 93363

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G28631
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Bagley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William John Fischer

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213-01-3626

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1919

8. AGE: Years 25 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John I
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Schnieder
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gerzon Hill Road

18 (a) Funeral director Tilly and Zeiler INC.
(b) Address 403 S. Wolfe St.

19 (a) MAY 8 1945 (Date received by registrar) Huntington Hollander, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to May 6 1945, and that I last saw him alive on May6 1945

	Duration
Immediate cause of death Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hallow M. D.
Address Balto City Hosp Date signed 5/7/45

G28632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G28632 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 Parkin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Parkin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Florence Thompson Wilkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Gea Wilkins

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53. | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name John Thompson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Martha Hines
15. Birthplace Baltimore Md

16 (a) Informant Mrs Ella Pierson
(b) Address 117 Parkin St

17 (a) burial (b) Date thereof 5/9/45.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem
Location 2900 B. Fed St

18 (a) Funeral director John Cowan Co
(b) Address 901-03 Hollins St

19 (a) Registered by (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945 at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-1945 to 5-6-1945, and that I last saw h— alive on 5/6 1945.

Immediate cause of death	Duration
Myocarditis	10 days
Due to Pneumothorax	15 days
Due to Oedema	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Date signed 5/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28633 | BALTIMORE CITY HEALTH DEPARTMENT | G28633

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 212 S. Collington Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 S. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Rogowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1901

8. AGE: Years	Months	Days	If less than one day
44	4	4	hr. min.

9. Birthplace Biloxi Miss. (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Horses

FATHER
12. Name Dominic Rogowski
13. Birthplace Poland

MOTHER
14. Maiden Name Josefina Chojnowski
15. Birthplace Poland

16 (a) Informant Agnes Rogowski
(b) Address 212 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 9 45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus (Cem
Location Balto. City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) MAY 8 1945 (Registered by registrar) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5- 1945, at 9:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer J. Mancini M.D. Medical Examiner.
Date signed May 5, 1945

X

G28634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Yaffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Joseph Yaffe
(b) Address 1303 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-45 (month) (day) (year)

(c) Cemetery or crematory Reservoir Hill
Location Park Ht & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Signature of registrar) (b) Registrar

MAY 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6-45 19..., at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941, to May 6 1945 and that I last saw her alive on May 6 1945.

	Duration
Immediate cause of death Bronchopneumonia	2 days
Due to Chronic Myocarditis & Hypertension	unknown
Due to	
Other Conditions Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cochrane M.D.
Address 1211 W Mulberry Date signed 5/6/45

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28635 ✓ (G28635 Registered No.)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital 10 Mun
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 N. Smallwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Shapiro

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-45 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom
Location Wenger Mill Rd

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St.

19 (a) MAY 8 1945 (Date rec'd by reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 19 45, at 11-20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 19 45 to 5/5 19 45, and that I last saw h alive on 5/5 19 45

Immediate cause of death	Duration
Acute Pulmonary Edema	hrs.
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 5/5/45

X

G28636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G28636 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin G. Paxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-14-75

8. AGE: Years 71. | Months 8 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Benjamin E. Paxton
13. Birthplace Mass.

MOTHER 14. Maiden Name Sadie Arnold
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/45

(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John E. Hagan
(b) Address 3600 E. Baltimore St.

19 (a) (Date rec'd by registrar) MAY 8 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6-1945, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1945, to 5-6-1945, and that I last saw h[illegible] alive on 5-6 1945.

	Duration
Immediate cause of death overwhelming infection, fecal peritonitis due to ruptured appendix	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-28-45

Major findings of operation: peritonitis due to ruptured appendix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Burnett, M.D.
Address J. H. H. Date signed 5-7-45

PRINT WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ascertained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

G28637 Registered No.

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1360 N. Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Pernell

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Owen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6/1919

8. AGE: Years 26 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Wm Gaither

13. Birthplace Md

MOTHER 14. Maiden Name Mary Scott

15. Birthplace Md

16 (a) Informant Wm Gaithers

(b) Address 1360 N. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Geo. B. Kelso Md

18 (a) Funeral director 1303 Preadman

(b) Address

(a) (b) Registrar

MAY 8 1945 Date received (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1945 at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1945 to 5/6 1945, and that I last saw her alive on 5/6 1945.

Immediate cause of death — Tuberculous Peritonitis — Duration 6 mos

Due to

Due to

Other Conditions Pulmonary Tbc

(Include pregnancy within 3 months of death)

Date of operation April 12, 1945

Major findings of operation: Tbc peritonitis

of autopsy: — Tbc Peritonitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Perry Fetterman M. D.

Address University Hosp Date signed 5/6/45

Huntington Williams, M.D.

Fetterman

G28638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G28638 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 141 N. Monastery Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 141 N. Monastery Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME WILLIAM JOSEPH HAID

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth V. Haid

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1887

8. AGE: Years 58 | Months 0 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Marble Contractor

11. Industry or business Self

FATHER

12. Name Joseph Wm. Haid

13. Birthplace Austria

MOTHER

14. Maiden Name Wilhelmina K. Hildesheim

15. Birthplace Austria

16 (a) Informant Mrs. Elizabeth V. Haid

(b) Address 141 N. Monastery Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/45 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Howard Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Maryland

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 8 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1945, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 8, 1945, to May 5, 1945, and that I last saw him alive on May 4, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George A. Kirop M.D.

Address 3030 Edmondson Ave. Date signed 5/7/45

X

628639 ✓ 628639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp V

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Oliver Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Leah Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1890

8. AGE: Years	Months	Days	If less than one day
54	7	2	hr. min.

9. Birthplace Carroll County Md.
(Town, county, and state)

10. Usual Occupation Guard
11. Industry or business Schemuet Rubber

FATHER
12. Name William Martin
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruby
15. Birthplace Maryland

16 (a) Informant Mrs. Leah B. Martin
(b) Address 4007 Belvedere Ave.

17 (a) Burial (b) Date thereof 5/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Freedom Wesley Chapel
Location

18 (a) Funeral director Harry E. Weer
(b) Address Sykesville, Md.

19 (a) (Date must be registered within 5 days) Huntington, Maryland

MAY 8 1945

VS 351

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 7 05 P M

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 7 1945 5 P.M.
(b) Where did injury occur? Union Ave & Clipper Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Shot self

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 8 1945

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G28640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G28640 Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N Hilton St.
(c) Hospital or institution: Ashburton House
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 N Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Anita Lambert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John W
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 19, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank R Baum
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Schneider
15. Birthplace Baltimore

16 (a) Informant John W Lambert
(b) Address 2004 N Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAY 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1942, to May 7 1945, and that I last saw h[illegible] alive on May 5 1945.

Immediate cause of death Carcinoma Brain — Duration 2 Mos.
Due to
Due to
Other Conditions Metastasis Lung Carcinoma of breast. (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Janet Fisher M. D.
Address 1822 N Washington Date signed 5/8/45

628641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. 628641

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Home
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Harford Ave
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country [illegible]

3 (a) FULL NAME Susanna Somers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert H. Somers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1880

8. AGE: Years	Months	Days	If less than one day
65 66	10	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER 12. Name Charles Harrison
13. Birthplace Md.

MOTHER 14. Maiden Name Agnes Rankin
15. Birthplace Md.

16 (a) Informant Robert H. Somers
(b) Address Ridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-45 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity
Location St. Mary's City, Md.

18 (a) Funeral director H. C. Matthaeyer Sons.
(b) Address Leonardtown, Md. Huntingtown, Williamsport, Md.

19 (a) MAY 9 1945 (Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1945, to 5-8 1945, and that I last saw her alive on 5-8 1945.

Immediate cause of death Peritonitis	Duration
Due to Ruptured Appendix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-11-45
Major findings of operation: Gang. appendicitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. McCormack M. D.
Address Maryland General Hosp. Date signed 5-8-45

G28642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G28642

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 William St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 William St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Neal

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Katherine Schwartz Neal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15-1864

8. AGE: Years 81 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name William H. Neal
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Jane Arnet
15. Birthplace

16 (a) Informant Mrs Katherine Neal
(b) Address 1215 William St

17 (a) Burial (b) Date thereof 5-8-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 MAY 8 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to May 5 1945.
That I last saw him alive on May 3 1945.

Immediate cause of death: Cirrhosis of liver — Duration 8 mos.
Due to: Arteriosclerosis — 6 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1279 William St Date signed 5/7/45

VS 150

G28643 G28643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Tuscany Rd.
(Usual place of abode location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Adelaide Gould

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1878

8. AGE: Years 67 Months 2 Days 10 If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Brokerage

11. Industry or business

FATHER
12. Name Jane E. Ingram
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Matthai
15. Birthplace Maryland

16 (a) Informant Mrs Mary I. Purnell-Taylor
(b) Address 309 Tuscany Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Memorial Co.
(b) Address 1044 N. Howard Ave.

19 (a) MAY 8 1945 (Date rec'd by registrar)

Interring for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1945, at 4 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to May 8 1945 and that I last saw him alive on May 8 1945

Immediate cause of death: Cardio-Resp. Failure — Duration

Due to: Lymphosarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizabeth Sprague, R.N.H.
Address Date signed 5-8-45

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G28644 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County Talbot ~~Balto~~
(c) City or town ~~Baltimore~~ Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Dorchester (Dower Alley)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Percy Ellis Satchell

3 (b) If veteran, name war No
(c) Social Security Account No. 220-16-922

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary E Satchell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 19 1893

8. AGE: Years	Months	Days	If less than one day
52	2	17	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Carpentering

FATHER
12. Name Chas. E. Satchell
13. Birthplace md

MOTHER
14. Maiden Name Sarah Leighton
15. Birthplace Maryland

16 (a) Informant Mrs Mary E. Satchell (Wife)
(b) Address Easton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md
18 (a) Funeral director Ellis Clark
(b) Address Easton Md.
19 (a) MAY 8 1945 (Date rec'd by registrar) (b) Registrar Huntington Hollowell

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1945, at 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1945 to 5-6 1945
and that I last saw ~~him~~ alive on 5-6 1945

Immediate cause of death Intracranial neoplasm — Duration .....
Due to ....
Due to ....
Other Conditions ....
(Include pregnancy within 3 months of death) over
Date of operation 5-4-45
Major findings of operation: Brain neoplasm
of autopsy: Neoplasm of Brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature R. Fankhouser M. D.
Address Univ Hosp Date signed 5-6-45
R. Fankhouser X

Please write plainly, with pen and ink. Every item must be answered. Be sure that the information given is correct and complete. Physicians: please write the causes of death clearly and legibly. Ages, especially important.

45 BALTIMORE CITY HEALTH DEPARTMENT G28645
CERTIFICATE OF DEATH 1647 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-17
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BASIL KATZ (BAFALA TKATZ)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace male Nurse, Austria (Town, county, and state)

10. Usual Occupation male Nurse

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Austria

MOTHER 14. Maiden Name unknown
15. Birthplace Austria

16 (a) Informant Levindale Home
(b) Address Delafordere & Greenspring Ave

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Jos Peirce Inc
(b) Address 1439 E. Balto St

MAY 8 1945 (b) Huntington Williams (Registrar)
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 11 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to May 7 1945 and that I last saw h[e] alive on May 7 1945

Immediate cause of death Hemorrage — Duration
Due to injury
Due to
Other Conditions Carcinoma of left bronchus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide suicide
(b) Date of occurrence May 7 45 at 11 a M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury knife - stabbed self

23. Signature A. Goldstein M. D.
Address 3505 N. Charles St Date signed 5-7-45

Approved: Howard J. Maddox M.D. per Robert Le Fetra M.D.

VS 150

Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB- 93461

Registered No. G28646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2470 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Morton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906?-?-?

8. AGE: Years 39? or 40? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Md.a
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Morton (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Wade
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 5-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location [illegible]

18 (a) Funeral director J. P. Lunberry
(b) Address 519 Mosher St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAY 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7- 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4- 1945, to 5-7- 1945, and that I last saw h im alive on 5-7- 1945.

Immediate cause of death	Duration
Cardiac failure	?
Due to	
Due to	
Other Conditions Pneumo-Cerebral Tuberculosis	3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 5-7-45

X

28647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G 28647
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave & North Bend Rd
(c) Hospital or institution:
Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 N. Fanvale St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife James Carroll Wade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 | 25 | 1870

8. AGE: Years 74 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Williams
13. Birthplace Baltimore - Md

MOTHER
14. Maiden Name Elizabeth Longley
15. Birthplace Baltimore - Md

16 (a) Informant E. T. Wade
(b) Address 628 Aisquith St - Balto - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. City

18 (a) Funeral director Jos. Kaminkes Inc
(b) Address 602 Wash. Blvd.

MAY 8 1945 (b) Huntington Williams, M.D.
(Date rec'd by local reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 28 1945 to May 5 1945, and that I last saw h-- alive on May 5 1945

Immediate cause of death Cer. Thrombosis — Duration 1 yr.

Due to Hypertension C. V. D. — 2 yrs.

Due to

Other Conditions Hypostatic Pulmonary Congestion — Several days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harriet M Stokes M.D.
Address 715 Frederick Date signed 5-9-45

X

G 28648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G 28648

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3222 Kingsley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Kingsley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Shunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John T. Shunt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1865

8. AGE: Years 80 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Beckmann
13. Birthplace Germany

MOTHER
14. Maiden Name Meinhardt
15. Birthplace Germany

16 (a) Informant Charles P. Shunt
(b) Address 3222 Kingsley St

17 (a) Burial (b) Date thereof May 11 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry G. Immerst
(b) Address 4204 Edgewood Ave

19 MAY 8 1945 Registrar for Williamsburg, Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to May 7 1945 and that I last saw her alive on May 6 1945.

Immediate cause of death Carcinoma of Liver — Duration 3 mos

Due to

Due to

Other Conditions Arteris-sclerosis
Rectal Stricture
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Frederick Ave Date signed 5-7-45

G-28649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G-28649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Broadmap

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 1869

8. AGE: Years 36 | Months - | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Samuel Broadmap

13. Birthplace Va

MOTHER 14. Maiden Name Nannie Perkins

15. Birthplace Va.

16 (a) Informant Nannie Singleton

(b) Address 406 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location Q. A. County Md.

18 (a) Funeral director Mrs. Robert A. Whitby Dept

(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by Local Registrar) (b) Huntington Williams M.D. Registrar

MAY 8 1945

VS 151

MEDICAL CERTIFICATION 35

20. DATE OF DEATH May 5, 1945, at 9 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5/5/45 at 6 45 A. M.

(b) Where did injury occur? 406 N. Caroline St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Shot during altercation

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed May 5 1945

X

G28650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G28650

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 N. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Hoffman St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Lindsay

3 (b) If veteran, name war

3 (c) ~~Social Security~~ Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) ~~Single~~, married, widowed, or divorced Married

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1886

8. AGE: Years 58 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Prince Edward Co., Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name David Saunders
13. Birthplace Va

MOTHER 14. Maiden Name Agnes Brown
15. Birthplace Va

16 (a) Informant Richard Lindsay
(b) Address 303 N. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Prince Edward Co. Va

18 (a) Funeral director Mrs. George W. Woodland
(b) Address 1631 Druid Hill Ave

MAY 8 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945, to May 5 1945, and that I last saw ____ alive on ____.

Immediate cause of death: Coronary Thrombosis — Duration 2

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. T. Woodland M. D.
Address 861 Harlem Ave Date signed 5-6-45

VS 150

G 28651 350232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 28651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. Seminary Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mae Shoultz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: black
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Albert Shoultz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-6-00

8. AGE: Years 44 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Matthews
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Lindsay
15. Birthplace Va.

16 (a) Informant Albert Shoultz
(b) Address 803 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1945 (month) (day) (year)
(c) Cemetery or crematory Family Lot.
Location Brownsburg, Va

18 (a) Funeral director Wm. Lemmon & Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar
MAY 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 at 7:11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945 to 5-6- 1945 and that I last saw her alive on 5-6- 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Hypertensive cardiovascular	
Due to renal disease	
Other Conditions Obesity	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William T. Dixon
Address Johns Hopkins Hospital Date signed 5/6/45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G-28652 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Information supplied by the

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address III8 N.Eutaw Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. III8 N.Eutaw Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arabella Linthicum

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Alva Henry Linthicum
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 26, 1868

8. AGE: Years	Months	Days	If less than one day
77	I	IO	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Brewer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ann Elizabeth West
15. Birthplace Baltimore, Md.

16 (a) Informant Miss. Elizabeth G. Linthicum
(b) Address III8 N.Eutaw Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location 1800 Greenmount Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue, Md.

19 MAY 8 1945 (b) Huntington Matthews, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1945, at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945, to May 6 1945, and that I last saw h.e.r. alive on May 6 1945.

Immediate cause of death Cardio-Respiratory failure.
Due to pulmonary Edema
Due to Pneumonia Lobar - Vascular disease
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Edward Day M.D.
Address 2134 St Paul St Date signed 5/6/45

VS 160

93c

G28653

AB93214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 136

Registered No. G28653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W. 23rd. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stedman Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Lottie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-20-1904

8. AGE: Years	Months	Days	If less than one day
40	7	14	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Fields
13. Birthplace Va.

MOTHER
14. Maiden Name Georgia Bright
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5-8-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) 1945 (b)
(Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4- 1945 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20- 1945, to 5-4 1945, and that I last saw h im alive on 5-4- 1945.

Immediate cause of death	Duration
Due to Pulmonary Tuberculosis	(7)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Balto. Md. Date signed 5-6-45

VS 150

Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 28654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

Registered No. C 28654

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 East 21st Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 East 21st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Hogan McKeever

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Francis P. McKeever
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name D. Hogan
13. Birthplace Ireland

MOTHER
14. Maiden Name B. Moran
15. Birthplace Ireland

16 (a) Informant Miss A.G.McKeever
(b) Address 523 East 21st Street

17 (a) Burial (b) Date thereof 5/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E 22nd St

MAY 8 1945
(a) Date rec'd by registrar (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1945, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1945, to May 7 1945, and that I last saw her alive on April 6 1945.

Immediate cause of death — Duration
(a) Myocarditis with decompensation — 6 weeks
Due to
(b) arteriosclerosis and arterial hypertension — years
Due to
(c) Carcinoma of the thyroid gland — years
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Straughn M.D.
Address 10 E Biddle St Date signed 5/8/45

G28655

Purviance

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 N. Eden
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 N Eden
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Henretta Purvience

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Purvience

(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business .....

FATHER
12. Name Levi Foxbur
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mc Mason
15. Birthplace Md.

16 (a) Informant Nicley White
(b) Address 1433 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Brooklyn A. A. Co. Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421, E. Jefferson St.

MAY 8 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1945 to May 7 1945 and that I last saw h[illegible] alive on May 6 1945.

Immediate cause of death ..... Duration

Mitral Insufficiency .....

Due to ....

....

Due to ....

....

Other Conditions ....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. Edward Fisher M.D.

Address 1629 Monument Date signed 5-7-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G28656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home
(c) Hospital or institution: North Broadway
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. Oakdale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs. Lepha S. Rockwell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Mr. Rockwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1871

8. AGE: Years 74 | Months 1 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Isaac Stoel
13. Birthplace New York

MOTHER
14. Maiden Name Harriet Decker
15. Birthplace Illinois

16 (a) Informant Mrs Dan Fenn
(b) Address 311 E. Oakdale Rd

17 (a) Burial (b) Date thereof May 10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Chicago Ill.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) 1945 (b) ...
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to May 8 1945, and that I last saw her alive on May 5 - 8 1945.

Immediate cause of death Myocardial infarction — Duration 4 d

Due to Arteriosclerotic heart disease — several years

Due to —

Other Conditions Anginal syndrome severe

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury —

23. Signature Marvin N. Davis M. D.
Address Church Home Date signed 5-8-45

X

correction is especially important. Physicians: please write the causes of death clearly and legibly.

G-28657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G-28657

Please write the causes of death clearly and legibly. Physicians: please see that information entered is correctly supplied. Cause and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 Laurens St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 LAURENS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM P. FAIRBANK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife MARY PIATT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 14, 1863

8. AGE: Years	Months	Days	If less than one day
82	1	22	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation BUTCHER
11. Industry or business

FATHER
12. Name CHARLES E. FAIRBANK
13. Birthplace MD.

MOTHER
14. Maiden Name JANE V. HALE
15. Birthplace MD.

16 (a) Informant JENNIE P. RENNIE
(b) Address 234 LAURENS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 8, 1945 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT
Location GREENMOUNT AVE. & OLIVER ST.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1500 EUTAW PLACE

19 (a) MAY 8 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1945, 19, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1945 to May 6 1945, and that I last saw h[illegible] alive on May 5 1945.

Immediate cause of death	Duration
Hypo-Static Pneumonia	One day
Due to Chr Myocarditis	several years
Due to Chr Arteriosclerosis	several years
Other Conditions Old age rc	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Keown
Address 1938 Linden Ave. Date signed 5/7/45 (M. D.)

VS 150

G28658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G28658
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Seaton Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1905.

8. AGE: Years	Months	Days	If less than one day
40	1	5	hr. min.

9. Birthplace Amherst, Va.
(Town, county, and state)

10. Usual Occupation Contractor.

11. Industry or business

FATHER
12. Name Amherst, Va.
13. Birthplace Seaton Robinson.

MOTHER
14. Maiden Name Sallie Willis
15. Birthplace Amherst, Va.

16 (a) Informant Mrs. Hester Boykin.
(b) Address 1041 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5, 8 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 1945 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1945, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1945 to 5/5 1945, and that I last saw h[illegible] alive on 5/5 1945.

Immediate cause of death: Malignant Hypertension — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M.D.
Address 512 Mosher St. Date signed 5/6/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

G 28659

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 N. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 N. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viva N. Ashley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francis L. Ashley

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 9th 1880

8. AGE: Years 64 | Months 9 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John J. Crouch
13. Birthplace Md.

MOTHER
14. Maiden Name Dora Fratz
15. Birthplace Md

16 (a) Informant Francis L. Ashley
(b) Address 1918 N. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 45 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cemetery
Location Rock Hall Md.

18 (a) Funeral director F. B. Kuppert Inc
(b) Address 1545 N. Eutaw St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1945, at 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945 to May 6 1945, and that I last saw her alive on May 6, 1945.

Immediate cause of death Hypertension-
Cardio-vascular Disease-
Haemplegia-left side-

Due to

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norbert C. Nitsch M.D.
Address 2151 Wilkens Ave. Date signed 5-7-45 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G28660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine M. Unstot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married~~, widowed, or ~~divorced~~. Widow

6 (b) Name of husband or ~~wife~~ Thomas H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1875

8. AGE: Years 69 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Allen
13. Birthplace W Va

MOTHER
14. Maiden Name Unknown
15. Birthplace W Va

16 (a) Informant Barney White
(b) Address 802 N Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-45 (month) (day) (year)
(c) Cemetery or crematory
Location Westernport. Md

18 (a) Funeral director John G Horan
(b) Address 3000 E Baltimore St

19 (a) 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to May 7 1945 and that I last saw h~~e~~d alive on May 7 45.

Immediate cause of death Carcinoma of Coecum — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas B Marsh M. D.
Address 801 N Linwood Date signed 5/7/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5106 Harford Rd.

G28661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28661
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd.
(c) Hospital or institution:
Schneider Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Melvin Ave Catonsville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose C. Owen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-1865

8. AGE: Years	Months	Days	If less than one day
79	5	28	hr. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John M. Platt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Ruff
15. Birthplace Germany

16 (a) Informant Miss Loyd M Platt
(b) Address 36 Melvin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 0-9-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 (a) Filed by registrar Huntington Williams M.D. Registrar
10-45

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 12:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to May 9 1945, and that I last saw her alive on May 6 1945

Immediate cause of death	Duration
Carcinoma of Uterus	3 years
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence none at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. J. Ruck M.D.
Address 5706 Harford Rd Date signed 5/8/45

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 150

G28662 BALTIMORE CITY HEALTH DEPARTMENT G28662

CERTIFICATE OF DEATH

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1261 6416 Grant
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Darmstadt

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 13 1877

8. AGE: Years	Months	Days	If less than one day
67	5	24	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name PHILLIP DARMSTEADT
13. Birthplace GERMANY

MOTHER
14. Maiden Name REGENA BARTHOLOW
15. Birthplace GERMANY

16 (a) Informant MARY A. DARMSTEADT (SISTER)
(b) Address 429 N. LAKEWOOD AVE.

17 (a) BURIAL (b) Date thereof MAY 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zadek
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by Registrar) (b) Registrar

MAY 8 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7- 1945, at 7 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-7-45 at 6 P.M.
(b) Where did injury occur? Route 40, 66 15th St. Essex
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from a truck

23. Signature Howard J. Mullecio M.D.
Medical Examiner.
Date signed 5-8-45

Huntington Pittsville, Md.

G 28663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 28663

1862

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
SINIA HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 McELDERRY ST.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME LOUIS J. LANG

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife MARY E. LANG
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAR. 1 1879

8. AGE: Years	Months	Days	If less than one day
66	2 3	7	..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant ALBERT L. LANG (SON)
(b) Address 4432 RASPE AVE.

17 (a) BURIAL (b) Date thereof MAY 11/95
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD
18 (a) Funeral director Lilly Lutz Jr
(b) Address 403 S. WOLFE ST.
19 (a) 1895 (b) .....
(To be filled in by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8/1895, at 12 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7/1895, to 5/8 1895, and that I last saw h[illegible] alive on 5/8/1895.

Immediate cause of death Cardio-Resp. failure — Duration .....
Due to Cardiac Decompensation .....
Due to Coronary Occlusion / Myocardial Infarction .....
Other Conditions Pulmonary Infarction .....
? Bilat. fractured fibulae .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(d) Accident, suicide, or homicide Accident
(b) Date of occurrence April 23, 1895 at 6 A.M.
(c) Where did injury occur? 2222 McElderry St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell from bedroom window to yard below
23. Signature [illegible]
Address [illegible] Date signed 5/8/95

Attended by Huntington Williams, M.D. Approved: Robert Lee Taylor M.D. 5/10/95

G28664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G28664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. Irvin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lionel Hoechstetter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jean
6 (c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.) 10-1-09

8. AGE: Years 35 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation engineer
11. Industry or business

FATHER
12. Name Leopold Hoechstetter
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Brokemeier
15. Birthplace Germany

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Vernon Cemetery
Location Pittsburgh Pa.

18 (a) Funeral director Saint Lordheimer Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by Local Registrar) (b) Huntington Williams, M.D.

MAY 9 1945

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 4:0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945 to May 8 1945, and that I last saw him alive on May 8 1945

Immediate cause of death: Lymphosarcoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ross L. McLean
Address Johns Hopkins Date signed 5-8-45

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~6386980~~ 469980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120B

Registered No. 628665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Orchard Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John E. Lawrence
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) 2-27-14
8. AGE: Years 31 | Months 2 | Days 11 | If less than one day hr. min. (2-27-14)
9. Birthplace Del. (Town, county, and state)
10. Usual Occupation School teacher
11. Industry or business

FATHER
12. Name Wm. Lawrence
13. Birthplace New Jersey

MOTHER
14. Maiden Name Catherine Davis
15. Birthplace New Jersey

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 5/9/45 (month) (day) (year)
(~~Burial, cremation, or~~ removal)
(c) Cemetery ~~or crematory~~ Shiloh
Location New Jersey
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St
19 MAY 9 1945 Huntington Williams Mfr
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945 at 2 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-4-45 1945 to 5-8- 1945 and that I last saw him alive on May 5- 1945
Immediate cause of death (a) Exhaustion
Cachexia — Duration 4 yrs.
Due to (b) Ulcerative Colitis
Due to (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation May 27, 45
Major findings of operation: Ulcerative colitis
Hostomy, colostomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George Bunch M. D.
Address J. H. H. Date signed 5-8-45

G28666

JO #93477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 ✓ G28666 Registered No.

Please write plainly with pen or information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1713 N. Caroline St. (If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME Katie Bridget Keenan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 1, (1862) 1872

8. AGE: Years	Months	Days	If less than one day
(83) 73	-4-	-6-	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER

12. Name Owen O'Rourke

13. Birthplace England

MOTHER

14. Maiden Name Kathleen Curran

15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cox Inc.

(b) Address 1217 St. Paul St.

19 (a) MAY 9 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1945, at 9:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 6, 1945, to May 7, 1945, and that I last saw her alive on May 7, 1945.

Immediate cause of death Cardiac failure — Duration 4 hrs 2 days

Due to Hypertensive Cardiovascular disease — 5

Due to ..... — 6

Other Conditions Pleural effusion — 7

Early Coloan Carcinoma

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature E. Woodward M. D.

Address Baltimore City Hospitals Date signed 5-8-45

(over) 93D

VS 150

G28667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G28667 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Ramsay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Ramsay St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Sekyra Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-03-7809

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Hermina Sekyra
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1883

8. AGE: Years: 62 | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Bohemia (Town, county, and state)
10. Usual Occupation: Barber
11. Industry or business: "

FATHER
12. Name: (Unknown) Sekyra
13. Birthplace: Bohemia

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Walter Sekyra Jr.
(b) Address: 705 Highwood Drive.

17 (a) (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Hill
Location: Balto. Md.

18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1217 St. Paul St.

19 MAY 9 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8/45 19.. at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1945 to 5-8 1945 and that I last saw h[illegible] alive on 5-8 1945

Immediate cause of death	Duration
Acute Cardiac Failure	1dy
Due to Cardiovascular Renal	6mos
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph G Laucks M. D.
Address 1717 Washington Blvd Date signed 5/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 160

628668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48B

Registered No. 628668

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Jackson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Jackson St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta C. Walton

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife David W. Walton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 28, 1890

8. AGE: Years 55 | Months 2 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Fletcher Stickels.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Waters
15. Birthplace Baltimore Md

16 (a) Informant Dave W. Walton
(b) Address 1818 Jackson

17 (a) Burial (b) Date thereof 5-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Duncan Cook Inc
(b) Address 1217 St Paul St

19 MAY 9 1945 Filed by registrar [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1944, to May 8 1945, and that I last saw he alive on May 7 1945

Immediate cause of death: Carcinoma uterus — Duration: 7 mos

Due to:

Due to:

Other Conditions Diabetes Mellitus — 15 mos

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. A. Stevens M. D.

Address 2418 Harford Rd Date signed 5-8-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6-28669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6-28669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1639 Warwick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 Warwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Gross

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1869

8. AGE: Years 76 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business —

FATHER
12. Name (Unknown) Gross
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Katherine Gross
(b) Address 1639 Warwick Ave

17 (a) Burial (b) Date thereof 5/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAY 9 1945 (Date rec'd by registrar) (b) Hunting for William Cook Inc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 12 11/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to May 8 1945
and that I last saw h[illegible] alive on May 7, 1945

Immediate cause of death — Duration

Myocardial insufficiency
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy, M.D.
Address 2327 Eastern Ave Date signed 5/8/45

VS 150

6286.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. 6286.0

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 W. Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 W. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE R. JEFFERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William I.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1875

8. AGE: Years 69 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Bloomsburg, Penna.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Russell
13. Birthplace Unknown

MOTHER
14. Maiden Name Edith Hutchinson
15. Birthplace

16 (a) Informant Julian R. Henderson
(b) Address 3909 Wilkins Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 9 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 25 1945 to May 7, 1945, and that I last saw h[illegible] alive on May 7, 1945

Immediate cause of death: Left Hemiplegia.

Due to

Due to

Other Conditions Chr. Nephritis.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.

Address 720 Med. Arts Bldg. Date signed 5/8/45

VS 150

G28671 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G28671

CERTIFICATE OF DEATH 133a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore 14
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 California Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Heim

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-8321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Doris Heim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/7/93

8. AGE: Years	Months	Days	If less than one day
52	2	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Millwright
11. Industry or business

FATHER
12. Name Michael A. Heim
13. Birthplace Germany

MOTHER
14. Maiden Name Eleanora Nagle
15. Birthplace Balto. Md

16 (a) Informant Doris Heim
(b) Address 3034 California Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 12 45 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Balto. Co. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.

19 (a) ____ (b) ____ (Date rec'd by registrar) Huntington Will, Registrar

MAY 9 1945

vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945 to May 7 1945 and that I last saw him alive on May 7 1945

Immediate cause of death Respiratory failure — Duration 11days

Due to Uremia + acidosis

Due to Pyelonephritis & septicemia - Renal shutdown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard J. Traband Jr.
Address University Hospital Date signed 5/9/45

X

G 28672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 F

G 28672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hospital
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Laupheimer

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Maurice W. Laupheimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1/1879

8. AGE: Years 65 | Months 5 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name George Germroth
13. Birthplace Pittsburgh

MOTHER
14. Maiden Name Mary Wise
15. Birthplace Md.

16 (a) Informant Mr. Maurice D. Laupheimer
(b) Address 2910 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Hunting for Williamsville, N.Y.

19 (a) MAY 9 1945 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1945, at 6:12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 5/8 1945, and that I last saw her alive on 5/7 1945.

Immediate cause of death Carcinoma of Liver — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Charles E. Edmunds Jr. M.D.
M. D.
Address Md. Gen'l. Hospital Date signed 5/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 28673 Registered No. (over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 Marydell Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 Marydell Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA BEULAH KNOBLOCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widow

6 (b) Name of husband or wife Harry Knobloch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1878

8. AGE: Years	Months	Days	If less than one day
66	5	1	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name -Oliver Cox
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Beulah Hilderbrant
15. Birthplace Balto., Md.

16 (a) Informant Mr. James W. Kemp
(b) Address 340 Marydell Rd.

17 (a) Burial (b) Date thereof 5/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 9 1945 (date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1945 at 5 00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 5/7 1944 and that I last saw him alive on 5/5 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alden H. Counter M. D.
Address 4209 Hurd Ave Date signed 5-8-45

VS 180

G28674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G28674 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. Conway St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lewin Lou Sorrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-1917.

8. AGE: Years 27 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Northern Neck, Richmond Co., Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Veney

13. Birthplace Richmond Co., Va.

MOTHER 14. Maiden Name Hannah Sorrell

15. Birthplace Richmond, Va.

16 (a) Informant Robert Sorell.

(b) Address 902 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 (month) (day)

(c) Cemetery or crematory Fredericksburg, Va

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) MAY 9 (Date received by registrar) (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1945 to 5/5 1945, and that I last saw h alive on 5/5/45 19

Immediate cause of death Toxic nephritis + pneumonia

Due to Second + third degree burns.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 22/2

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 4/21/45 at P.M.

Where did injury occur? 630 W. Conway St. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)

(e) Means of injury Fire from lighted cigarette

23. Signature Dr. Schreiber M.D.

Address Univ. Hosp. Date signed 5/5/45

VS 150

For Dr. J. Lemmon, by Howard J. Morris, M.D.

G 28675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 28675 ✓ 838 Registered No.

Physicians: please write the correct age is especially important. Be sure information entered on the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2332 E. Baltimore Str.
(c) Hospital or institution: b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 E. Baltimore Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Nelson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Stephen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/ 14/ 76

8. AGE: Years	Months	Days	If less than one day
68	6	21 23	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Zeiler
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Dietz
15. Birthplace Balto., Md.

16 (a) Informant Margaret Weber (niece
(b) Address 2332 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 / 11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Riley Inc
(b) Address 403 S. Wolfe Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams

VS 1 MAY 9 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/ 1945 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1942 to May 1945 and that I last saw her alive on May, 6 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	32 hrs.
Due to Hypertension	
Due to Arteriosclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Feller, M.D. M. D.
Address 2739 Eastern Ave. Date signed 5/7/45

X

G28676 ✓ G28676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH P3a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife George A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/1880

8. AGE: Years	Months	Days	If less than one day
65	3	13	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. Earl Miller
(b) Address 935 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5.10.45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd

18 (a) Funeral director Harry A. Wetzler
(b) Address 4101 E Monument Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7/45 19.. at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6/45 19.. to 5/7/45 19.., and that I last saw her alive on 5/6 1945.

Immediate cause of death	Duration
Cerebral hemorrhage (Left)	5 days
Due to Hypertension, arterio-	
Due to sclerosis	1 Yrs
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Sutton M. D.
Address 4 N Fulton Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28677 ✓ G-28677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1278

Registered No. .....

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write; especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave + Hilleland St

(c) Hospital or institution West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 612 S. Payson St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) **FULL NAME** Estella A Weidner

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Robert A.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 18 1889

8. AGE: Years 56 | Months 3 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name John Ball

13. Birthplace Maryland

MOTHER 14. Maiden Name —

15. Birthplace Maryland

16 (a) Informant Mr. Robert A. Weidner

(b) Address 612 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5.11.45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd.

18 (a) Funeral director Harry H Wiske

(b) Address 4101 Edmondson ave

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7/45 19..., at 3 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945 to 5/7 1945 and that I last saw h[er] alive on 5/7 1945.

Immediate cause of death	Duration
Toxic Hepatitis	
Due to Hepatorenal Syndrome?	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/2/45

Major findings of operation: Chronic gall bladder disease

of autopsy: Liver + Kidneys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Alberto Adam M.D.

Address West Baltimore Gen. Hosp. Date signed 5/9/45

VS 150

G 28678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 142

G 28678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4612 Hamptnett ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 8yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4612 Hamptnett Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Manfre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Clara Quaster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	6	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Manfre
13. Birthplace Italy

MOTHER
14. Maiden Name
15. Birthplace Italy

16 (a) Informant Mrs Clara E. Quaster
(b) Address 4612 Hamptnett Ave.

17 (a) Burial (b) Date thereof 5. 10. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave + North Point Rd

18 (a) Funeral director Harry W. Witzke
(b) Address 4101 Edmondson Ave

19 (a) MAY 9 (b) 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 6.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1935 to May 7 1945 and that I last saw deceased alive on May 5 1945.

Immediate cause of death Coronary Occlusion — Duration 5 minutes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Grady M.D.
Address 5106 Harford Road Date signed 5/8/45

for H. B. McHenry, by Howard J. Clemens, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28679

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G28679
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max J. Myers

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1933

8. AGE: Years	Months	Days	If less than one day
12	1	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Vernon W. Myers 2nd
13. Birthplace

MOTHER
14. Maiden Name Dolores D. Emerick
15. Birthplace Penna

16 (a) Informant Vernon W. Myers
(b) Address 1801 Hollins St.

17 (a) Burial (b) Date thereof May 9, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ebenezer Cemetery
Location Winfield, Carroll Co.
18 (a) Funeral director Harry H. Leitzke
(b) Address 1401 Edmondson Ave.
MAY 5 1945
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6- 1945, at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot of Heart
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 1914
(a) Date of injury 5-6-45 at 8:45 A M.
(b) Where did injury occur? 1801 Hollins St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - revolver
23. Signature Howard J. Anderson M.D.
Medical Examiner.
Date signed 5-6-45

VS 151

G28630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G28630 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Mt Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Susan T. Norton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Train Dispatcher
11. Industry or business B & O. R. R.

FATHER
12. Name John W. Kelly
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Elizabeth Lanier
15. Birthplace Balto Md

16 (a) Informant Mrs Susan J. Kelly
(b) Address 409 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5.11.45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd

18 (a) Funeral director Harry H Wiltke
(b) Address 2101 Edmondson Ave

19 (a) MAY 9 1945 (Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1945 to 5/8 1945, and that I last saw him alive on 5/5 1945.

Immediate cause of death Heart failure

Due to Coronary Occlusion

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St. Agnes Hosp Date signed 5/9/45

940

correct age is especially important. Physicians: please write the

G28681 G28681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 A Newkirk Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kalfas

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45	6		hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Restaurant
11. Industry or business

FATHER	12. Name	?
	13. Birthplace	?
MOTHER	14. Maiden Name	?
	15. Birthplace	?

16 (a) Informant Mrs Elitis
(b) Address Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mountlawn.
Location Baltimore, Md.

18 (a) Funeral director John Miller
(b) Address 2334 Jefferson St.

19 (a) MAY 9 1945 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1945 at 4 00 AM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Lineaweaver M.D.
Medical Examiner.
Date signed 5-6-45

G28682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G28682

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Ellerslie Avenue
(c) Hospital or institution: Saint Elizabeth's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Ellerslie ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Morgan (Sister Mary Elizabeth)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1873

8. AGE: Years	Months	Days	If less than one day
72	0.	24	hr. min.

9. Birthplace London, England (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name George Joseph Morgan
13. Birthplace London, England

MOTHER
14. Maiden Name Kathleen Mc Gee
15. Birthplace London, England

16 (a) Informant Mother Mary Amelda
(b) Address 3725 Ellerslie Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1945 (month) (day) (year)
(c) Cemetery or crematory St Elizabeth Home
Location Balto Md

18 (a) Funeral director Henry N. Jenkins Son & McCulloch Orchard
(b) Address

MAY 9 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 1 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1940 to May 7 1945 and that I last saw h.er alive on May 6 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Chronic Hypertension.	
Due to Chronic Interstitial Nephritis.	2 yrs.
Other Conditions General arterio Sclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. J. Rhudy
Address 1129 N Paul St Date signed M 5 D 7/45

X

G 28683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. G 28683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Wolfe
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Park Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Hornstein

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-0795

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah FRIEDA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day min.

9. Birthplace Memphis Tenn. (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Moses Hornstein
13. Birthplace Poland

MOTHER
14. Maiden Name Sarah
15. Birthplace Poland

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) MAY 9 1945 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1945 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945 to 5/8 1945 and that I last saw h[illegible] alive on 5/8 1945.

Immediate cause of death Uraemia

Due to renal insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/27/45

Major findings of operation: Amputated right kidney

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Hornstein

Address Sinai Hosp Date signed 5/9

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAMES COLLETT.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 28684 G 28684

CERTIFICATE OF DEATH

13B

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 208 McMechen St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME James Collett 14

If U. S. Veteran specify WAR

(a) Residence: No. 208 McMechen St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	Sing

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) 12-11-1916

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	4	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Agent

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Herbert Collett

14. BIRTHPLACE (city or town) (State or country) M D

MOTHER

15. MAIDEN NAME Rebecca ?

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Rebecca Collett Watson

(Address) 208 McMechen st

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Auburn Cem Date 5-12-45

19. UNDERTAKER Watkins & Jackson

(Address) 916 Pennsylvania ave

20. FILED ..... 19.... Registrar.

MAY 9 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 8, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec 14 1944 to May 8 1945

I last saw him alive on May 8, 1945. Death is said to have occurred on the date stated above, at 4 P. M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Epilepsy	
Intracranial	

Other contributory causes of importance

Influenza	

Was an operation performed? no Date of —

For what disease or injury? —

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19....

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury Hors[illegible]

Nature of injury [illegible]

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Hugh D Humphreys M. D.

(Address) 12 E Dead Hill Av

OCCUPATION is very important. See instructions on back of certificate.

VS 8

X

G-28635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

G-28635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 Annapolis Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Annapolis Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose H. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21 1870

8. AGE: Years 68 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER 12. Name Harrison

13. Birthplace Balto. Co.

MOTHER 14. Maiden Name Stevenson

15. Birthplace Balto Co

16 (a) Informant Celeste Miller

(b) Address 2222 Annapolis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)

(c) Cemetery or crematory Balto. Comm

Location Edgar Road Annex

18 (a) Funeral director Edgar H. Valentine

(b) Address 2326 Aisquith St.

19 (a) (Date rec'd by registrar) MAY 9 1945 Huntington Williams M.R.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 1944 to May 7 1945 and that I last saw h alive on May 6 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 2 months

Due to: Hypertension — 5 years

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Setzfeld M.D.

Address 320 Lamont Date signed 5/7/45

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5/31/a

Registered No. G-28686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 E.Preston St.
(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
Md.
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 E.Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August C.Klingenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Josephine Klingenberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.5-1888

8. AGE: Years 57 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER
12. Name Adam Klingenberg
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Masek
15. Birthplace Not Known

16 (a) Informant Josephine Klingenberg
(b) Address 1011 E.Preston St.

17 (a) Burial (b) Date thereof May 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John F. Melby
(b) Address 2334 Jefferson St

19 (a) Date rec'd by Registrar MAY 9 1945 (b) Signature Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May-45 19 45, to May 7 1945, and that I last saw h[illegible] alive on May 5 1945

Immediate cause of death	Duration
Coronary Thrombosis	Subdle
Due to Hypertension Cardio-Ren	2
Due to Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Bloom M.D.
Address 1206 E.Oliver St Date signed 5/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G-28687 X G-28687

468940 BALTIMORE CITY HEALTH DEPARTMENT 462 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Kew Gardens R.I. (If outside city or town limits, write RURAL and give town)
(d) Street No. 8444 Kew Gardens Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Martin A. Saxe.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Helen.
6 (c) If alive, give age 37. years

7. Birth date of deceased (mo., day, yr.) 3-26-94

8. AGE: Years 50 | Months 1 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Travelling Salesman

11. Industry or business

FATHER
12. Name Sandor Saxe
13. Birthplace Penn

MOTHER
14. Maiden Name Sarah Yaring
15. Birthplace Austria

16 (a) Informant Records.
(b) Address

17 (a) [illegible] Cemetery (Burial, cremation, or removal) (b) Date thereof May 9 (44) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location New Hyde Park N.Y.

18 (a) Funeral director Dan'l Hondlesman & Son
(b) Address 1402 Eutaw St

19 (a) (Date received by Registrar) MAY 9 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May - 9 1945 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1945 to May - 9 1945 and that I last saw him alive on May - 9 1945

Immediate cause of death	Duration
Carcinomatosis with Cachexia (CANCER)	
Due to Adeno Carcinoma of Body & Tail of Pancreas	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 1, 1945

Major findings of operation: Diagnosis Carcinoma of Pancreas and Peritoneum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 5-7-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1402

Registered No. G28688

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Every item of information should be carefully supplied.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1515 N. Calhoun St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rudolph Dixon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18, 1910

8. AGE: Years 34 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Johnson

13. Birthplace Md.

MOTHER

14. Maiden Name Marie Johnson

15. Birthplace Md.

16 (a) Informant Mrs. Rudolph Dixon

(b) Address 1521 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co., Md.

18 (a) Funeral director Jesse W. Redden

(b) Address 436 W. Biddle St.

MAY 9 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6- 1945 at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1945 to 5-6 1945 and that I last saw her alive on 5-6 1945

Immediate cause of death: Dehydration, acidosis, shock

Due to: Intestinal obstruction

Due to: Paralytic ileus ?

Other Conditions: Infected 4½ mo pregnancy - aborting

(Include pregnancy within 3 months of death)

Date of operation: none Ileus, infected pregnancy, aborting

Major findings of operation:

of autopsy: as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Shyrock M. D.

Address University Hospital Date signed May 8, 45

VS 150

G28689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

Registered No. G28689

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Lowndes St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Kotkowski - KOSTKOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/40

8. AGE: Years 4 | Months 4 5 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Thomas Kotkowski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Blochstein
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 1601 Lowndes St

17 (a) Burial (b) Date thereof May 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Anne Arundel Co.

18 (a) Funeral director John A. Greflinger
(b) Address 423 S. Paca St

19 (a) MAY 9 1945 (b) Registrar Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1945, at 8:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1945, to 5/8 1945, and that I last saw h[illegible] alive on 5/8 1945

Immediate cause of death	Duration
Resp. Failure	
Due to Exhaustion	
Due to Pneumonia - Bronchitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. K. Spielberg M. D.
Address Mercy Hosp. Date signed 5/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 28690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V160a

Registered No. G 28690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green to
(c) Hospital or institution: University Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Mc Phail Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ancil Robert Moore

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 10. 1945

8. AGE: Years | Months | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Angil D. Moore
13. Birthplace W. Va

MOTHER
14. Maiden Name Rose E Beyer
15. Birthplace St Marys Co Md

16 (a) Informant Mrs A. D. Moore
(b) Address 1114 Mc Phail

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Ave

18 (a) Funeral director Thos J. Emory
(b) Address Hollins & Gilmor

19 (a) (b)

Registered by registrar MAY 9 1945 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1945, at 3:[illegible] P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1945, to 5/8 1945, and that I last saw h[illegible] alive on 5/8 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Intracranial Hemorrhage	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R C Clowney M. D.
Address Union Hospital Date signed: 5/8

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 28691 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Carrie Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband ~~Father~~ John T. Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1865

8. AGE: Years 80. Months 2 Days 16 If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name William T. Wenderoth
13. Birthplace Germany

MOTHER
14. Maiden Name (Unknown)
15. Birthplace "

16 (a) Informant John T. Russell
(b) Address 914 N. Payson St

17 (a) Burial (b) Date thereof 5/11/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAY 9 1945 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1945, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941, to May 9 1945, and that I last saw her alive on May 8 1945

Immediate cause of death Chronic Myocardial Degeneration — Duration 2 yrs

Due to Arteriosclerotic C.V. Disease — Duration 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. F. Schraudenbach M. D.

Address 5217 Baltimore Md. 5/9/45

Copy age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G-28692 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 S.Clinton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 S.Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Moltz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mary Spangler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.29,1877

8. AGE: Years	Months	Days	If less than one day
67	7	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name not known
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Caroline Eckhardt
15. Birthplace Baltimore Md.

16 (a) Informant Mrs.Wirsing
(b) Address 902 S.Clinton St.

17 (a) Burial (b) Date thereof 5/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (a) (b) Huntington Williams
(Date received by registrar) (Signature of registrar)
MAY 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945, to May 9 1945, and that I last saw him alive on May 8 1945.

Immediate cause of death Asthenia due to Cerebral Hemorrhage

	Duration
As Impressed Failure	2-12-45
Due to Cerebral Hemorrhage	4-30-45
Due to Nond.	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Schumacher
Address 5721 Estaline Date signed M. D. 5-9-45

G-28693 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G-28693

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution: Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Theresa Finnegan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Owen Finnegan
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/25/73

8. AGE: Years	Months	Days	If less than one day
72	1	12	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER — 12. Name Nicholas Hofst
13. Birthplace Balto Md

MOTHER — 14. Maiden Name Jane Hofst
15. Birthplace Balto Md

16 (a) Informant Gertrude Finnegan (daughter)
(b) Address ~ 508 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Frank V. Piperton
(b) Address 2018 E. Balto St

MAY 9 1945 (Date received by registrar) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 6 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945, to May 7 1945, and that I last saw her alive on May 7 1945.

Immediate cause of death: Cerebral Vascular Hemorrhage — Duration

Due to: Hypertension Cardio-Vascular Disease

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Wm. E. Faust III

Address Women's Hospital Date signed 5-7-45 M. D.

X

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

G28694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G28694

JO #93463

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Hershey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1907

8. AGE: Years	Months	Days	If less than one day
37	9	21	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Hershey
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elma Habacker
15. Birthplace Pennsylvania

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Removal (b) Date thereof 5/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lancaster
Location Lancaster, Pa.

18 (a) Funeral director J. Tickner & Sons
(b) Address N. K. Peffer or Bolton, Md. Huntington Williamsport, Md.

19 (a) MAY 9 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 5, 1945 to May 9, 1945, and that I last saw him alive on May 8, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	(a)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible], M. D.
Address City Hospitals Date signed 5-9-45

VS 150

28695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

Registered No. 628695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County.....
(c) City or town Richmond (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 3 - Box 66 (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Maggie E. Straith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-65

8. AGE: Years 80 | Months 1 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace West Virginia (Town, county and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Laban Givins
13. Birthplace West Virginia

MOTHER
14. Maiden Name Malinda Conley
15. Birthplace West Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/10/45 (month) (day) (year)
(c) Cemetery or crematory Oakwood
Location.....

18 (a) Funeral director J. Tickner & Sons
(b) Address 1000 Belvidere Ave, Baltimore

19 MAY 10 1945 (Date rec'd by registrar) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 5:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945 to May 9 1945, and that I last saw h[illegible] alive on May 9 1945.

	Duration
Immediate cause of death Peritonitis	
Mesenteric Thrombosis	
Due to Arteriosclerosis, gen'l	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....
23. Signature Edward Packard M.D.
Address Johns Hopkins Date signed 5/9/45

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

6-28696 LEASH BALTIMORE CITY HEALTH DEPARTMENT 6-28696

CERTIFICATE OF DEATH 81a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 William St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Ronald Joseph Leash
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1942

8. AGE: Years	Months	Days	If less than one day
2	7 5	28	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name Clarence C. A. Leash
13. Birthplace York, Pa.

MOTHER 14. Maiden Name Marian Bragin
15. Birthplace Louistown, Pa.

16 (a) Informant Mariann Leash
(b) Address 832 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director John F. Denny, Inc.
(b) Address 215 Light St.

19 (a) MAY 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1945, at 2:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945 to 5/9 1945, and that I last saw him alive on 5/9 1945

Immediate cause of death Respiratory failure — Duration —
Due to Pneumococcus meningitis — Duration 3 days
Due to Pneumococcus — Duration —

Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Kenneth G. Gee, M.D.
Address Sydenham Hosp Date signed 5/9/45

X

28697 ✓ G-28697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

Please answer all questions as completely as possible. Information should be carefully supplied, write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 and Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.1day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Armistead Hotel, Fayette & Holliday Sts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Reed

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-7727

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.20, 1897

8. AGE: Years	Months	Days	If less than one day
48	2	18	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Deck Engineer
11. Industry or business Sea-faring

FATHER
12. Name Lawrence Reed
13. Birthplace New York

MOTHER
14. Maiden Name Margaret?
15. Birthplace Balto., Md.

16 (a) Informant Records, US Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road.

18 (a) Funeral director Howard V. Blight, Jr.
(b) Address 4914 Belair Road

19 MAY 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 7:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1945 to May 8 1945, and that I last saw h.im alive on May 8 1945.

	Duration
Immediate cause of death myocardial degeneration	Unknown
Due to Atrophic cirrhosis of liver	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/10/45; 5/1/45
Major findings of operation: Paracentesis; Palliative surgery on liver
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.C.Archer M. D.
Address US Marine Hospital Baltimore, Md. Date signed 5/8/45

VS 150

G 28698 ✓ G 28698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Druid Hill (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Elijah Jane Cole

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex F
5. Color or race col
6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-12-1863

8. AGE: Years 82 | Months 3 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business —

FATHER
12. Name Benjamin Quille
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Sally E. Marguder
15. Birthplace Calvert Co Md.

16 (a) Informant Mrs. Edna Dillard
(b) Address Atlantic City N.J.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory Mt Auburn 5-10-45
Location Balto. Md.

18 (a) Funeral director Crawford A Gaddis
(b) Address 2101 Mc Culloh St.

19 MAY 10 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to 5-7 1945
and that I last saw her alive on 5-7 1945

Immediate cause of death ..... Duration

Cardio-Vascular .....
Due to Renal Disease .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....
23. Signature H. W. Butler
Address 2033 Eutaw Place Date signed 5/9/45

VS 150

G28699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G28699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 and Wyman Park Drive
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bartlett, James

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1894

8. AGE: Years	Months	Days	If less than one day
50	10	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Guard --Curtis Bay
11. Industry or business

FATHER
12. Name Thomas H. Bartlett
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Slaughter
15. Birthplace Balto., Md.

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore, Md.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-13-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat.
Location Furbush Rd. Towson, Md.
18 (a) Funeral director Jas. L. McCarey
(b) Address 130 E. Fayette St.
19 MAY 10 1945 (Date rec'd by registrar) Huntington Willi... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to May 9m 1945, and that I last saw h im alive on May 9 1945.

Immediate cause of death	Duration
Acute bleeding from duodenal ulcer	3d ays
Due to Early atrophic cirrhosis of liver	Unknown
Due to	
Other Conditions Arteriosclerosis, Bronchopneumonia, systemic (Include pregnancy within 3 months of death)	

Date of operation none done
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.C. Archer M. D.
Address US Marine Hospital Baltimore, Md. Date signed 5/9/45

VS 150

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28700

JL - 93421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28700 Registered No.

Please write or print plainly with indelible pencil. Physicians: please write the correct age is especially important. Be sure to fill in the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Henrietta Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John H. Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1877

8. AGE: Years	Months	Days	If less than one day
68 ?	1	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Rosena Clamon
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-10-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.
18 (a) Funeral director James H. McCauley
(b) Address 1900 E. Fort Ave.
19 (d) MAY 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2, 1945, to May 7 1945, and that I last saw her alive on May 7, 1945.

Immediate cause of death Kidney failure & uremia — Duration ?
Due to Pyelonephritis nephrosis — —
Due to Bilateral renal calculi — —
Other Conditions Bilateral Staghorn calculi — ?
Hydrops of gall bladder Cholelithiasis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E Woodward
Address Baltimore City Hospitals signed M. D. 5-8-45

VS 150

134a

28701 CWK-88765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G-28701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-10-9
(e) Length of stay in Baltimore (yrs., mos., or days) 71-5-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Spence Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Brehm

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Nellie Bly Brehm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1873

8. AGE: Years 71 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Balto.)
(Town, county and state)
10. Usual Occupation Glass blower
11. Industry or business Swindell Bros

FATHER
12. Name Michael Brehm
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Wisema
15. Birthplace Maryland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Lexington Huntington Ave. Baltimore, Md.

19 (a) MAY 10 1945 (b) Registrar
(Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 12:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1944, to May 8 1945, and that I last saw him alive on May 8 1945.

Immediate cause of death	Duration
Heart failure	days
Due to Generalized pulmonary emphysema	25 years
Due to Arteriosclerosis, Bronchiectasis	②
Other Conditions Hypertensive cardiovascular disease (not)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis A. Simon M. D.
Address Balto City Hospitals Date signed 5-7-45

106 B

VS 150

PRESS WHITE FIRMLY, WRITE UNDERLINING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G28702

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 Park Hgts Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 Park Hgts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanore Hardie

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ William C. Hardie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1851

8. AGE: Years 94 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Charles Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Townsend
15. Birthplace Md

16 (a) Informant Ella Cornelius
(b) Address 4420 Park Hgts Ave

17 (a) Burial (b) Date thereof 5/11/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAY 10 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1945, at 11.37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1945 to May 9 1945 and that I last saw h W alive on May 9 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	4/5/45
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Seibert M.D.
Address 4619 Park Heights Ave Date signed 5/9/45

G28703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G28703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 N. Montford Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP NOHA

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-5720

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary (nee Bartos)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1873

8. AGE: Years 72 yrs. | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Noha
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Emma Noha (daughter)
(b) Address 918 N. Montford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 Filed MAY 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 7 1945, and that I last saw h alive on 19

Immediate cause of death Uraemia Coma — Duration 5/4/45

Due to Ch. Nephritis — 11/1944

Due to Arteriosclerosis — 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Rysavy M.D.
Address 801 E. Kennedy St. Date signed 5/8/45

VS 150

Please write plainly, using pen and ink. Every item or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 28704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 28704

Please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5614 Fair Oaks Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5614 Fair Oaks Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth A Morse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband ~~or wife~~ Jesse S. Morse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10 1875

8. AGE: Years 69 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Wm. Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Riley
15. Birthplace Ireland

16 (a) Informant Mrs Emma Colt
(b) Address 120 Grand Ave Englewood N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-45 (month) (day) (year)
(c) Cemetery or crematory Harrison Cem.
Location Pearl River N.Y.

18 (a) Funeral director L. J. Rinaldi
(b) Address 5305 Harford Ave

19 (a) MAY 10 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9-45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945 to 5/9 1945 and that I last saw her alive on 5/9 1945

Immediate cause of death Hypertension Cardio-Vascular Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions Cerebral Hemorrhage — 5 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Tyler Holley M. D.
Address 3703 Harford Ave Date signed 5/10/45

G28705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1641

Registered No. G28705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Calhoun Sts.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Pfannenstiel

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife late Margaret M. —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 22, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	16	hr. min.

9. Birthplace New Jersey
(Town, county, and state)
10. Usual Occupation Sign Painter
11. Industry or business Shaw Brandt Co.

FATHER
12. Name Lewis Pfannenstiel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lulu Moeller
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Elsie Elsroad
(b) Address 1123 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave. west —

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 3 Hollins Street

19 MAY 10 1945 (Date rec'd by registrar) (b) Huntington Williams Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8- 1945 at 5 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Embolism of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-8-45 at 3.55 P.M.
(b) Where did injury occur? 1123 Washington Blvd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - revolver

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5-9-45

VS 151

G28706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G28706 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 827 N Eutaw St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Turner Bamberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/45

8. AGE: Years	Months	Days	If less than one day
		17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas S. Bamberger
13. Birthplace Balto Md

MOTHER
14. Maiden Name Gertrude W. Thomas
15. Birthplace Balto Md

16 (a) Informant Thos S. Bamberger
(b) Address 827 N. Eutaw St

17 (a) Loudon (Burial, cremation, or removal) (b) Date thereof May 10 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address McCulloh + Druid

19 (a) MAY 10 1945 (b) Registered
Registrar

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1945, at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1945 to 5/8 1945, and that I last saw h[illegible] alive on 5/8 1945.

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel

Address Md. Gen'l Hospital Date signed M. D. 5/8/45

G 28707 M 23631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

Registered No. G 28707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Fulton Ave
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	NB

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1945

8. AGE: Years	Months	Days	If less than one day
		1/2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name George Bert
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Evelyn Wright
15. Birthplace Talbot County Md

16 (a) Informant Evelyn Bert
(b) Address 2721 E. Monument St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL MAY 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 10 1945 Hunter Williams M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Prematurity	
Due to Cesarean section	
Due to Pre-eclampsia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/2/45
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 715 Eastern Ave Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2700

628703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 628708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 S. Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Compton

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth.

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb. 6-1866

8. AGE: Years 79 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Md. Dry Dock

FATHER 12. Name James S. Compton

13. Birthplace Balto. Co.

MOTHER 14. Maiden Name Lydia A. Hedrick

15. Birthplace Balto. Co.

16 (a) Informant Elizabeth Compton

(b) Address 1170 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month, day, year)

(c) Cemetery or crematory Loudon Park

Location Frederick Rd.

18 (a) Funeral director John A. Nathan

(b) Address 3300 E. Baltimore St.

19 (a) Date received by local registrar MAY 10 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945 to 5/9 1945, and that I last saw h M alive on 5/8 1945.

Immediate cause of death	Duration
Chronic Hypertension	
Chronic Nephritis	
Due to Arteriosclerosis	
uremia	
Due to Prostatectomy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 12 1945

Major findings of operation: ?

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Tankey

Address 441 S. Ellwood Av Date signed 5/10/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 460

G28709 Registered No.

Please write plainly with pen or typewriter. Physicians: please write the causes of death clearly and legibly. Be sure to answer correctly every question where information is available, and be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Dillon Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Taylor

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Barbara Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/95

8. AGE: Years	Months	Days	If less than one day
50	6	17	hr. min.

9. Birthplace: Tennessee (Town, county, and state)
10. Usual Occupation: Guard
11. Industry or business: Federal Bank

FATHER
12. Name: Pinkny Taylor
13. Birthplace: Tenn.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Tenn.

16 (a) Informant: Barbara Taylor (wife)
(b) Address: 3118 Dillon Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 / 12/45 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd.

18 (a) Funeral director: Tilly and Zeiler INC.
(b) Address: 403 S. Wolfe Street

19 (a) MAY 10 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 5/10 1945, and that I last saw h. (?) alive on 5/10 1945.

Immediate cause of death	Duration
C-R. Failure	
Due to ca of esoph, with generalized metastatic involvement.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3/10/45.
Major findings of operation: ca of esophagus.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. L. M. Brenner M.D.
Address Sinai Hospital Date signed 5/10

G28710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G28710 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 551 W. Hoffman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 00 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 551 W. Hoffman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Cobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	married

6 (b) Name of husband or wife Pinkey Cobbs
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan 6 1884

8. AGE: Years	Months	Days	If less than one day
61	4	1	hr. min.

9. Birthplace Prospect, Va.
(Town, county, and state)
10. Usual Occupation Driver
11. Industry or business Bethlehem Steel Co

FATHER
12. Name George Cobbs
13. Birthplace Va

MOTHER
14. Maiden Name Isabella Cobbs
15. Birthplace Prince Edward Co Va

16 (a) Informant Pinkey Cobbs
(b) Address 551 W. Hoffman st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-45 (month) (day) (year)
(c) Cemetery or crematory Prospect Cemetery
Location Prospect, Virginia

18 (a) Funeral director Wellington A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by Local Registrar) (b) Registrar

MAY 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1945, at 10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 5/5 1945 to 5/9 1945, and that I last saw him alive on 5/9 1945.

Immediate cause of death Acute Coronary Occlusion

Due to

Due to

Other Conditions Hypertension Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunter Williams M.D.
Address 1111 Lee Date signed 5/10/45

Hunterton Williams, M.D.

G28711 G28711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Frederick avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Frederick ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BROTHER ETHELBERT C.F.X. (JOHN D. ROCHE)

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1860

8. AGE: Years 84 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Louisville, Kentucky
(Town, county, and state)

10. Usual Occupation Xaverian Brother

11. Industry or business

FATHER
12. Name Richard Roche
13. Birthplace

MOTHER
14. Maiden Name Martha Witherton
15. Birthplace

16 (a) Informant Rev. Bro. Bartholomew C.F.X.
(b) Address 4409 Frederick avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evagis. Son Inc.
(b) Address 718 N. Mt. Royal Ave.

19 (a) (Date rec'd by reg.) MAY 10 1945 Huntington Wilkins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1945, to May 8, 1945 and that I last saw him alive on May 7 1945.

Immediate cause of death Myocardial Degeneration-Arteriosclero-sis. — Duration

Due to Senility-Parkinson Disease

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at Work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Wilkins, M.D.
Address 2151 Wilkens Ave. Date signed 5-8-45

X

G28712 G28712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 Mohawk Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia E. Barnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1854

8. AGE: Years	Months	Days	If less than one day
90	8	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name DeWarren H. Barnett
13. Birthplace Baltimore

MOTHER
14. Maiden Name Amelia Marsden
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. C. A. Roe
(b) Address 3716 Mohawk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by reg.) (b) Washington Williams, Registrar

MAY 10 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1944 to 19
and that I last saw h~~e~~r alive on May 8 1945

Immediate cause of death: Myocarditis — Duration: Last 6 mos

Due to

Due to

Other Conditions: advanced arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur ~~about home, on farm~~, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Dalbey M. D.
Address 2220 Garrison Blvd. Date signed

G28713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1925

Registered No. G28713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 E. 27th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3-E 27th St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Lyons

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1853

8. AGE: Years 61 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Lyons
13. Birthplace Ireland

MOTHER
14. Maiden Name Helen Cosgrove
15. Birthplace Ireland

16 (a) Informant John J. Lyons
(b) Address 3 E 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Leyner & Fleming
(b) Address 1426 Eutaw St.

19 (a) (b) Registrar
MAY 10 1945
Filed by registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 25 1945, to May 7 1945 and that I last saw h[illegible] alive on May 7 1945.

	Duration
Immediate cause of death: Chronic Myocarditis	4 yrs.
Due to: Auricular-ventricular Dysfunction	4 yrs.
Due to:	
Other Conditions: Pulmonary Edema	12 hrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry B. Athey
Address 2324 St. Paul St. Date signed 5/8/45.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 93526 G28714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

G28714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Augustus McCree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1938

8. AGE: Years 6 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Croner Mc Cree
13. Birthplace N. C.

MOTHER
14. Maiden Name Ida Rhodes
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph B. Lake, Jr.
(b) Address 1304 N. Central Ave

19 (a) Date received by registrar MAY 10 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945 19 4:45am M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8, 1945 to May 9 1945, and that I last saw h im alive on May 9, 1945.

Immediate cause of death: Pneumococcal type 3 — Duration: 1 day
Due to: meningitis — Duration: 7 longer
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Bumingham M.D.
Address BCH Date signed 5-9-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

28715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 ✓

Registered No. G28715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 Riggs Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 Riggs ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jos H. Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Male	White	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5th 1883

8. AGE: Years	Months	Days	If less than one day
61	9	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Hat Blocker

FATHER
12. Name William W. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Nicholoom
15. Birthplace Md.

16 (a) Informant John F Mauthe
(b) Address 9 S. Beckfield Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

MY (a) 1 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 9 - 1945 at 5-30 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malamis M.D. Medical Examiner.
Date signed 5-10-45

X

G-28716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 48 B

G-28716 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 N. Eden
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Eden
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Heath (Heath)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leroy Heath

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1902

8. AGE: Years 42 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Chester South Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Harris
13. Birthplace Chester S. C.

MOTHER
14. Maiden Name ?
15. Birthplace Chester S. C.

16 (a) Informant Leroy Heath
(b) Address 1217 N. Eden

17 (a) Removal (b) Date thereof 5/11/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Chester S. C.

18 (a) Funeral director Joseph G. Lockerman
(b) Address 1364 N. Central Ave

19 MAY 11 1945 Huntington Williamson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from May 9 1945, to May 10 1945 and that I last saw h[illegible] alive on May 10 1945.

	Duration
Immediate cause of death: Acute myocarditis	1 Day
Due to: Carcinoma of uterus	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Long Berry M. D.
Address 1420 E. Chase Date signed 5-10-45

VS 150

X

G2871.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G2871.7

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Calvert-
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 27-13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Edgewood Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME William Capehart Walke

3 (b) If veteran, name war W.W.I.

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie D Walke

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec-27-1894

8. AGE: Years 50 | Months 4 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Gas Rep. Co. of

11. Industry or business Balto.

FATHER 12. Name Edgar H Walke

13. Birthplace Virginia

MOTHER 14. Maiden Name Emily Smrue

15. Birthplace North Carolina

16 (a) Informant Anna D Walke (wife)

(b) Address 206 Edgewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-45 (month) (day) (year)

(c) Cemetery or crematory Church Hill

Location Queen Anne Co. Md.

18 (a) Funeral director Elliott & Mount Co.

(b) Address 108 W Mulberry

19 MAY 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 1.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to — 19 , and that I last saw him alive on May 10 1945

Immediate cause of death Coronary Occlusion — Duration Sudden

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. W. Saunders

Address 56 E Lexington St Balto. Md. Date signed 5/11/45 M D

VS 150

Please write plainly, with pen and ink. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 28718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert
(c) Hospital or institution:
Union Memorial 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. 7-14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4909 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs Richard K Meade~~ (Fannie Louise Meade)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Richard K. Meade
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 6-11-76
8. AGE: Years 68 Months 69 Days 10 If less than one day ____ hr. 28 ____ min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business none

FATHER
12. Name Charles E. Thomas
13. Birthplace Virginia

MOTHER
14. Maiden Name Mattie Hoskins
15. Birthplace Virginia

16 (a) Informant Sister (Mrs M.M. Boughman) (Married)
(b) Address 4909 Rolandview
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore
18 (a) Funeral director Edward Meyer Company
(b) Address 108 W. Monument
19 (a) MAY 11 1945 (Date rec'd by registrar) (b) Harding for Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1945, to 5-9 1945, and that I last saw h[illegible] alive on 5-9 1945.

	Duration
Immediate cause of death: Cardio-respiratory failure	
Due to: Hypertension	
Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W L Sweeney M. D.
Address Union Mem'l Hosp Date signed 5/10/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G28719 ✓ G28719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. 1

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supplied. Type or ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Bolton St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Bolton (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

4-1

3 (a) FULL NAME Robert J Halliday

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alvenda J Halliday
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 21 1865

8. AGE: Years	Months	Days	If less than one day
79	9	18	hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)
10. Usual Occupation none (retired)
11. Industry or business

FATHER
12. Name Robt J Halliday
13. Birthplace Balto Md

MOTHER
14. Maiden Name Christine Dick
15. Birthplace Balto Md

16 (a) Informant Mrs Alvenda M E Halliday (wife)
(b) Address 1602 Bolton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-45 (month) (day) (year)
(c) Cemetery or crematory Greenmt
Location Baltimore

18 (a) Funeral director Sherwood Mooney Co.
(b) Address 1080 Mott Ave

19 (a) MAY 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945 to May 9 1945 and that I last saw h[illegible] alive on May 9 1945

Immediate cause of death Cerebral Hemorrhage — Duration 5 days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W H Pearce M. D.
Address 2106 Eutaw Pl Date signed May 10/45

VS 150

G 2872.20

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G 2872.20

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 E. 20th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Morris Lathorn Maulsby

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 705-09-2004

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Nettie H.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Mar 24 1884

8. AGE: Years 60 | Months 11 | Days 8 14 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and State)

10. Usual Occupation B. & O. Railroad

11. Industry or business Carpenter

FATHER 12. Name Augustus A.C. Maulsby

13. Birthplace Balto.

MOTHER 14. Maiden Name Rebecca A. Howard

15. Birthplace Balto.

16 (a) Informant Mary Florence Maulsby

(b) Address 1116 E 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 11 45 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Greenmount & North Ave

18 (a) Funeral director W. W. E. Dugan's Sons

(b) Address 110 W. Lord & Anna St.

19 (a) MAY 11 1945 (Date the day received) (b) Waiting for William Register

MEDICAL CERTIFICATION 45

20. DATE OF DEATH May 8 1945 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to May 8 1945.
and that I last saw h alive on May 8 1945

Immediate cause of death: Carcinoma of cardiac portion of stomach — Duration: Days

Due to:

Due to:

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.

Address 1121 Edmondson Ave Date signed 5/10/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6-28721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115B

Registered No. 6-28721

This item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N. Parrish St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Nelson Clifford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-21-70

8. AGE: Years	Months	Days	If less than one day
74 70.	7	14	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none.
11. Industry or business

FATHER
12. Name Alfred Clifford
13. Birthplace Md.

MOTHER
14. Maiden Name Manella ?
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. U. Nelson
(b) Address 1303 Pressman St

19 (a) MAY 11 1945 Date received by Registrar (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH May - 9 1945 at 12.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 7 1945, to May - 9 1945, and that I last saw h.im alive on May - 9 1945.

Immediate cause of death Shock

Duration

simp. otitis media laryngitis tonsillitis adenitis.

Due to ? septicemia

Due to S. hemol. strep.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-7

Major findings of operation: tracheotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature P. W. Williams M.D.
Address JHH Date signed 5-9

X

G 28722 ✓ G 28722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3321 Fredonick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 S. Fremdelintown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Anna Albiker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry W. Albiker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 - 1884

8. AGE: Years 60 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Fred'k Christopher
13. Birthplace Germany

MOTHER
14. Maiden Name Francis Elson
15. Birthplace Germany

16 (a) Informant Harry W. Albiker
(b) Address 325 S. Fremdelintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 (month) (day) 45 (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director F. D. Millhouse, Son
(b) Address 850 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1945 to May 9 1945 and that I last saw h[illegible] alive on May 9 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 8 minutes

Due to Hypertension BP 228/140

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3321 Fred Ave Date signed 5-9-45

MAY [illegible] Huntington Hillsdale, N.Y.

Medical examiner notified by [illegible]

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6287.23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

6287.23

Registered No.

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 S. Smallwood Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 438 S. Smallwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. Greffen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ernest F. Greffen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/10/1883

8. AGE: Years 64 | Months 14 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Hendericks
13. Birthplace Germany

MOTHER
14. Maiden Name Kerstey Feuch
15. Birthplace Germany

16 (a) Informant Edna F. Greffen
(b) Address 438 S. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director J. A. Kilfoyle Son
(b) Address 851 W. Baltimore St

19 (a) Huntington Williams (Date rec'd by registrar) MAY 11 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th 1945 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to May 11 1945. and that I last saw he alive on 5/11 1945.

Immediate cause of death Hypertensive Cardio vascular disease — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.

Address 20 W Mulberry Date signed May 11 1945

Corr X

G 28724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 28724 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert K. Coleman ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-03-1232

4. Sex Mo. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 21 at 1891

8. AGE: Years 53 | Months 5 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James J. Coleman

13. Birthplace Cambridge, Md.

MOTHER 14. Maiden Name Fannie Herbert.

15. Birthplace Frederick, Md.

16 (a) Informant Ida Holtz

(b) Address 609 N. Carolina St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location B. A. Co. Md.

18 (a) Funeral director Byron Magnis & Wright

(b) Address 724 Pisquata St.

19 (a) MAY 11 1945 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8- 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1945 to 5-8 1945 and that I last saw h[illegible] alive on 5-8- 1945

Immediate cause of death Bronchial Pneumonia — Duration 3 wks.
and Pleurisy — 5 wks.
Due to Colds
Due to and Exposure
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas. R. Blake
Address 1327 N. Central Ave. Date signed 5/9/45

VS 150

G 28725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 88

Registered No. G 28725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Baltimore Eye Ear Throat Charity Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 + 4 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 14 E. Lexington St. (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadler, Mary

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Bl | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Sadler | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 24 - 1881

8. AGE: Years 64 | Months | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER 12. Name James Presw
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary Byrd
15. Birthplace Va

16 (a) Informant Joseph Sadler
(b) Address 14 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Kyle Bros. & H. Holland
(b) Address 1611 Druid Hill Ave.

19 (a) MAY 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1945, at 1.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1945, to 5/10 1945, and that I last saw her alive on 5/9 1945.

Immediate cause of death	Duration
Peripheral Vascular Failure	
Due to Cardiac Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/9/45
Major findings of operation: Mature Cataract O.S.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Small M. D.
Address 18 W. Read St Balto. Md. Date signed 5-10-45

VS 3

Correct age is supremely important. Physicians: please write the causes of death clearly and legibly.

6287:26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

6287:26 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the necessary supplementary information. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 536 Laurens St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 536 Laurens St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Tilson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1879

8. AGE: Years 66 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Lynchburg, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Scott
13. Birthplace Lynchburg, Va

MOTHER
14. Maiden Name Julia Scott
15. Birthplace Lynchburg, Va

16 (a) Informant Marie Brown
(b) Address 536 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Stallings
(b) Address 1631 Druid Hill Ave

19 (a) 1 1945 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 5/8 1945, and that I last saw h[illegible] alive on 5/7 1945

Immediate cause of death Chronic Myocarditis

Due to Hypertension & Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 5/10/45

VS 150

G-28727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G-28727 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1889

8. AGE: Years 56 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Gordonsville, Va (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Sue Robinson
(b) Address 1706 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee V. Hyland
(b) Address 1631 Druid Hill Ave.

19 (a) MAY 11 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 9 1945, and that I last saw h[illegible] alive on May 9 1945

Immediate cause of death: Pneumonia — Duration: About 9 days

Due to Spread to streptococcic condition and sepsis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Garland Shirkoff M.D.
Address 1534 Druid Hill Ave. Date signed May 10

VS 150

X

File G28728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

Registered No. G28728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Sulgrave Rd.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Sulgrave Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rena A. Frank,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eli Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9th. 1875

8. AGE: Years 69 | Months 6 5 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business none

FATHER
12. Name David Ambach
13. Birthplace Germany.

MOTHER
14. Maiden Name Fannie Burgunder
15. Birthplace Balto. Md.

16 (a) Informant Eli Frank Jr.
(b) Address 2007 Sulgrave Rd,

17 (a) (Burial, cremation or removal) Burial (b) Date thereof 5/11/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew Cemetery
Location Balto. Md.

18 (a) Funeral director David Bondheim's Son
(b) Address 1902 Eutaw Pl.

19 (a) MAY 11 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th. 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1934, to May 10 1945, and that I last saw h.er alive on May 9, 1945.

Immediate cause of death	Duration
Carcinoma, cervix uteri	1 yr.
Due to	
Due to	
Other Conditions Hemiplegia	3 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Bettleman M. D.
Address 1041 St. Paul St. Date signed 5-10-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 28729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2476 Shirley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Becky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace ? Russia

MOTHER
14. Maiden Name Sonia
15. Birthplace Russia

16 (a) Informant Hoyt Berman
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Belvedere Ave

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Baltimore St

MAY 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to May 9 1945 and that I last saw h[illegible] alive on May 9 1945

	Duration
Immediate cause of death Cardiorespiratory failure	
Due to Cerebral vascular accident	10 days
Due to Edema lung Hardening	10 days
Other Conditions Pneumonia (Include pregnancy within 3 months of death)	5

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Palmer M. D.
Address Mercy Hospt Date signed 5/9/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

28730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G-28730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Mills

3 (b) If veteran, name war

3 (c) Social Security Account No. 230-09-5276

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Amelia Va
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Everett Mills
13. Birthplace Amelia Va

MOTHER
14. Maiden Name Otelia Givens
15. Birthplace Amelia Va

16 (a) Informant Everett Mills Father
(b) Address Amelia Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof May 2-1945 (month) (day) (year)

(c) Cemetery or crematory Albright Cemetery
Location Amelia Va

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) MAY 11 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 19 45, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 5/9/45

G 28731 ~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G 28731

Please answer all questions in full. Use typewriter or print plainly in ink. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2236 Brunt
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 Brunt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara E. Parker PARKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months — | Days — | If less than one day hr. min

63

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Oscar Lloyd Taylor

(b) Address 2126 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location West Port

18 (a) Funeral director Va Brooks

(b) Address 1463 N. Carey St.

MAY 11 1945 (Date rec'd by local registrar) (b) Huntington Williams M.D. registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945 at 9:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 10 1945 and that I last saw he alive on May 9 1945.

Immediate cause of death	Duration
Chronic Myocarditis	3 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. D. Link M.D.

Address North Ave & Division Date signed May 10

G 287 32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G 287 32
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Scott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E THOMPSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife VIOLA A. THOMPSON
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) MARCH 1 1906

8. AGE: Years	Months	Days	If less than one day
39	2	10	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation STEEL WORKER
11. Industry or business BRANDT'S

FATHER
12. Name FREDERICK THOMPSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name HARRIOTT HIGDON
15. Birthplace MARYLAND

16 (a) Informant VIOLA A. THOMPSON
(b) Address 813 SCOTT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-15-45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A.A. Co.

18 (a) Funeral director Bernard C Harlow
(b) Address 121 E West St

19 (a) MAY 11 1945 (Date received by registrar) (b) Registrar Huntington Hitchens, MD

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH MAY 11, 1945, at 3:05 P.M.

21. I certify that I took charge of the remains described above, held an AUTOPSY (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-11-45 at 1:47 A.M.
(b) Where did injury occur? 813 Scott Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot by Burglar

23. Signature Robert Lee Fletcher M.D. Medical Examiner.
Date signed May 11 1945

G 28733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1146

G 28733 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2850 N. Charles St.
(c) Hospital or institution:

12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2850 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA J. BIRCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Hatch Birch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	6	hr. min.

9. Birthplace Reisterstown, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Amos A. Harryman
13. Birthplace Md.

MOTHER
14. Maiden Name Ann Howard Harding
15. Birthplace Md.

16 (a) Informant Mrs. Marie B. Ruppersberger
(b) Address 2850 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 11 1945 (Date rec'd by Local Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945, at 3:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945 to May 9 1945, and that I last saw h[illegible] alive on May 9 1945.

	Duration
Immediate cause of death Myocardial Infarction.	2 da.
Due to C.P.C. - Lungs	2 da.
Due to Fibrosis of Lungs.	8 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. W. Koons M. D.
Address 1207 St Paul St Date signed 5/10/45

E. W. Koons

G28734 ✓ G28734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 South Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town 107 S. Calhoun St. (If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME TILLIE HECK.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No
4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Stephen Heck
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 6. 1863
8. AGE: Years 81 | Months 82 | Days 7 | If less than one day: hr. ..... min. 3
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name: Peter Kreamer.
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Unknown
15. Birthplace: .. ..

16 (a) Informant: Tillie Heck.
(b) Address: 107 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May. 10.45 (month) (day) (year)
(c) Cemetery or crematory: Western Cem
Location: West Baltimore St. Ext.

18 (a) Funeral director: Robert L Brooks
(b) Address: 1338 Hollins St.

19 (a) MAY 11 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 945 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 8 1945.
and that I last saw her alive on May 8 1945.

Immediate cause of death ..... Duration
Cerebral hemorrhage 4 days
Due to Arterio-Sclerosis ? days
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work?)
(e) Means of injury .....

23. Signature Harry Lansman M. D.
Address 2687 Wrightwood Ave Date signed May 10 1945

X

G 28735 ✓ G 28735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1371 N. Stricker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1371 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elzie Devaughn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James —
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Blanche Allen
(b) Address 913 N. Patrick St

17 (a) Burial (b) Date thereof 5 · 14 · 45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Com-
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) MAY 11 (b) Huntington Williams, M
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to May 10 45
and that I last saw her alive on May 9 1945

Immediate cause of death

	Duration
Edwin Myocarditis	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature F. B. Linthicum M. D.
Address 1001 Park Ave Date signed May 10 1945

VS 8

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28736 ✓ G28736

TN. 93290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 620 Sarah Ann St (Or other descriptive location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bertha Bridges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Benjamin Bridges

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9th 1896

8. AGE: Years 48 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Ivamon Grey

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 11 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania Ave

19 (a) MAY 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th, 1945 19 , at 4.45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25-45 19 , to 5-7-45 19 .

and that I last saw her alive on May 7th 19 45 .

Immediate cause of death	Duration
Cardiac failure	5
Tremens	2
Due to Arteriosclerotic Heart	
disease. Chronic glomerulo	
Due to Nephritis	
Other Conditions Bilateral Pulmonary infects	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gauer

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E Worthington M. D.

Address Baltimore City, Md. Date signed 5-10-45

VS 150

TO BE WRITTEN IN PERMANENT, WASH-PROOF BLACK OR BLUE-BLACK INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 28737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G 28737 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Parkland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Kaufman Sklenar

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Jos Sklenar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27. 1858

8. AGE: Years 56 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Poland (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Geo Walkowicz

13. Birthplace Poland

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs W. Zaleski

(b) Address 2739 W. Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Blage Road

18 (a) Funeral director Thos J. Kenny

(b) Address Pulaski & Gilmor

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 19 45, at 4H M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 19 45, to 5/10 19 45, and that I last saw h[illegible] alive on 5/10 19 45.

Immediate cause of death	Duration
? Coronary Thrombosis	
Due to Rheumatic CVD	
Cardiac enlargement	
Due to moderate decompensation	
Goitre (? colloid)	
Other Conditions Liver damage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Taylor M.D.
Address WBGN Date signed 5/14/45

X

correctage is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grossfeld
G-28738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G-28738 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4108 Frankford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Frankford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John F. Petrik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary S. Petrik
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1875

8. AGE: Years	Months	Days	If less than one day
70	1	26	hr. min.

9. Birthplace Checoslovakia
(Town, county, and state)
10. Usual Occupation Tailor, RETIRED
11. Industry or business

FATHER
12. Name Frank Petrik
13. Birthplace Checoslovakia

MOTHER
14. Maiden Name Barbara Kubes
15. Birthplace Kubes

16 (a) Informant Mrs. Mary S. Petrik
(b) Address 4108 Frankford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 11 1945 (Date rec'd by registrar) (b) Huntingtown, Md. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th, 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1943 to May 8 1945 and that I last saw h[illegible] alive on 5-8 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 2 hrs.
Due to: Hypertensive arteriosclerosis —
Due to: Tuberculosis —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 5305 Harford Rd. Date signed 5/9/45

correct age is especially important. Physicians: please write the

VS 150

83a

C28739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

Registered No. C28739

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 N. Monroe St.
(c) Hospital or institution:

15 U

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HUGH MAGILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	216-10-2967

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	6	hr. min.

9. Birthplace St. Mary's Co., Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Richard H. J. Magill
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Mary L. Readmond
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Miss Ethel C. Magill
(b) Address 1900 N. Monroe St.

17 (a) Burial (b) Date thereof 5/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morganza Cem.
Location St. Mary's Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 5 11 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945, at 6:40 P M
is said to have

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945 to May 7 1945, and that I last saw him alive on May 7 1945.

Immediate cause of death: Arteriosclerotic or degenerative Heart Disease — Duration ?

Due to

NOTE Mr. Magill was in Ft. Howard Veterans Hospital from February 1945 until May 6, 1945. When he left this

Other Conditions against advice. I saw him only once on 5-7-45. at that

(Include pregnancy within 3 months of death)
Date of operation time he was very rea
Major findings of operation: —

of autopsy: —

PHYSICIAN Death. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Harrell Pierce M. D.
Address 312 Med. arts Bldg Date signed 5/11/45

VS 180

X

G-28740 ✓ G-28740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 N. Paca St.
(c) Hospital or institution:

4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas P. Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Julia P. Bosch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1883

8. AGE: Years	Months	Days	If less than one day
61	7	14	hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)
10. Usual Occupation Poultry dealer
11. Industry or business

FATHER
12. Name John P. Cunningham
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Divine
15. Birthplace Ireland

16 (a) Informant Helen Cunningham
(b) Address 311 N. Paca St.

17 (a) Burial (b) Date thereof 5/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Sons.
(b) Address 1900 Eutaw Place

19 (a) 1945 (b) Arrington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to May 10 1945, and that I last saw him alive on May 9 1945

	Duration
Immediate cause of death Coronary Thrombosis.	hours.
Due to Hypertension	3yrs.
Due to Chronic Brights Disease - Interstitial nephritis.	3yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Isadore
M. D.
Address Medical Arts Bldg. Date signed

VS 150

Dr. DeMarco Lic. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28741 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 28741
CERTIFICATE OF DEATH 93C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County —
(c) City or town WASHINGTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 LAMONT ST. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD. O. SPERLING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOWED.

6 (b) Name of husband or wife DECEASED

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-(60) 84

8. AGE: Years 63 (84) | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace CHICAGO ILL. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace " "

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace " "

16 (a) Informant MRS. JOHN ROSE
(b) Address WESTMINSTER MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-14-45 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location WASHINGTON D.C.

18 (a) Funeral director J. F. REESE
(b) Address WESTMINSTER MD.

19 (a) (Date rec'd by registrar) (b) Registrar

5-11-45 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 1945, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1945, to 5-11 1945, and that I last saw h[illegible] alive on 5-11 1945.

Immediate cause of death Pulmonary Edema — Duration

Due to Rheumatic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen S. Drake M. D.
Address Univ. Hospital Date signed 5-11-45

X

Please write the causes of death clearly and legibly. Physicians: please be careful that information should be carefully supplied. The correct age is especially important.

G-28742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G-28742 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4233 Old Frederick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4233 Old Frederick Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Russell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 14, 1876
8. AGE: Years 68 Months 7 Days 26 If less than one day hr. min.
9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H. Burgess
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Young
15. Birthplace Maryland

16 (a) Informant Harry R. Smith
(b) Address 4233 Old Frederick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 (a) MAY 12 1945 (registrar) Huntington Williams (registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 10 1945, and that I last saw h[illegible] alive on May 9 1945.

Immediate cause of death: (a) Hemiplegia: Left Sided. — Duration
Due to: Hypertension & C.V.D.
Due to: Uremic Nephritis
Other Conditions: Pulmonary Edema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roland C. Peterkin M. D.
Address 2151 Madison Ave Date signed 5/10/45

VS 150

X

age is especially important. Physicians: please write the causes of death clearly and legibly.

G28743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G28743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 E 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orris N Joyce

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife Harry B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1861

8. AGE: Years 84 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Nash
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Mulyard
15. Birthplace Md

16 (a) Informant Mrs Howard Statham
(b) Address Cape Charles City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Mt Lebanon Md

18 (a) Funeral director Wilson Lowe
(b) Address 1219 E Pond St

19 (a) MAY 12 1945 (Date received by Registrar) (b) Huntington Williams Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1935, to May 11 1945, and that I last saw h[illegible] alive on May 8 1945.

Immediate cause of death Carcinoma of Rectum — Duration 6 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Chalfant M. D.
Address 610 York Road Date signed May 11, 45

VS 150

X

G-28744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G-28744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 St. Paul st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances E. Schad

3 (b) If veteran, name war W

3 (c) Social Security Account No. NNE

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ George Schad.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23rd 1862

8. AGE: Years 83 | Months 3 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name John Arnold
13. Birthplace Germany

MOTHER
14. Maiden Name Kate (Unknown)
15. Birthplace Germany

16 (a) Informant Helen V. Rowe
(b) Address 1727 St. Paul St.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to May 10 1945; and that I last saw h[illegible] alive on May 9 1945.

	Duration
Immediate cause of death Pulmonary Embolism	1 day
Due to Chronic Myocarditis	2
Due to	
Other Conditions Senile dementia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Culbertson M.D.
Address 1727 St Paul St Date signed 5/14/45

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] supplied

C-28745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C-28745 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2934 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Creamer

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 16 1862

8. AGE: Years 82 | Months 4 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Creamer
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Catherine Green
15. Birthplace Balto. Co. Md.

16 (a) Informant Grace M. C. King
(b) Address 2934 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10-45 19... at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10-45 19... to 5-10-45 19..., and that I last saw him alive on 5-10-45 19...

Immediate cause of death	Duration
Pulmonary edema	
Due to Cardiac failure	
Due to Coronary occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 5-10-45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G 28746 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene M. Beaumont

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13th 1873

8. AGE: Years 72 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Westchester Pa.
(Town, county, and state)

10. Usual Occupation Shipyard

11. Industry or business Holtman Bros

FATHER
12. Name James Beaumont
13. Birthplace Coatesville Pa.

MOTHER
14. Maiden Name Mary Houltman
15. Birthplace Port Deposit Md.

16 (a) Informant Mrs Harmon
(b) Address 600 Whitelock st Sylesus 2-C

17 (a) Burial (b) Date thereof 5/14/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Hunnington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945 at 5-45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Jun death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH ~~Coughing~~
Cerebral Concussion; Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-10-45 14/1 5 P.M.
(b) Where did injury occur? McMechen & Dol. Royal
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 10 1945

VS 151

X

G28747 ✓ G28747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. PRINTING WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2445 E. Eager Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimcre
(c) City or town Baltimcre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E. Hepfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John D. Hepfer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1868

8. AGE: Years	Months	Days	If less than one day
76	8	9	hr. min.

9. Birthplace Chambersburg, Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mark Pugh
13. Birthplace Chambersburg, Pa.

MOTHER
14. Maiden Name Deck
15. Birthplace Chambersburg, Pa.

16 (a) Informant Clarance M. Hepfer - son
(b) Address 2445 E. Eager Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Chambersburg, Penna.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) MAY 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to May 11 1945 and that I last saw h[illegible] alive on May 9 1945

Immediate cause of death	Duration
Uremia Chronic Nephritis	2?
Due to	
Due to	
Other Conditions Myocarditis Cardiac Collapse	1 mo 2 weeks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas E Schimunek M. D.
Address 2929 E Eager St Date signed 5/11/45

VS 150

G28748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G28748 Registered No.

Physicians: please write the causes of death clearly and legibly. Be sure information about age is especially important. Please do carefully supply all items.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Wilkens ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 wilkens ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Haegerty

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife annie Beer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18-1864

8. AGE: Years 80 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Ret. Blacksmith

11. Industry or business

FATHER 12. Name Michael Heagerty
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Dunn
15. Birthplace Unknown

16 (a) Informant Mrs. annie Heagerty
(b) Address 1814 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St

19 (a) (Date received by registrar) MAY 12 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/p 1945 to 5/9 1945, and that I last saw h[illegible] alive on 5/9 1945.

Immediate cause of death Chronic enter- — Duration 2 yrs
Due to Rial nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Mueller M. D.
Address 2036 Wilkens ave Date signed 5/11/45

G28749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

Registered No. G28749

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hayden Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name Everett Bond

13. Birthplace ? Md.

MOTHER 14. Maiden Name Eliza Davis

15. Birthplace ? Md.

16 (a) Informant Friends

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)

(c) Cemetery or crematory St. Louis

Location Sykesville, Md

18 (a) Funeral director C. Harry Weer

(b) Address Sykesville, Md.

19 MAY 12 1945 (Date rec'd by local registrar) Huntington Willis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 45 at 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 19 45 to May 11 19 45, and that I last saw h[illegible] alive on May 11 19 45.

	Duration
Immediate cause of death Respiratory failure	
due to aspirations	
Due to ~~Due to~~ Meningococcal meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. Whittlesey M.D.

Address JHH Date signed 5-11

VS 150

G 28750

JL -,93519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 28750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 W. Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold Busch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/ 1895 ?

8. AGE: Years	Months	Days	If less than one day
49 50 ?	? 5	? 14	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Harry Busch
13. Birthplace ? Va

MOTHER
14. Maiden Name ? Emma Pettaway
15. Birthplace ? Va

16 (a) Informant B. C. H. "ecords
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah Brown Sr
(b) Address 108 W Montgomery

19 MAY 12 1945 (Date rec'd by registrar) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to May 9 1945, and that I last saw him alive on May 9 1945.

Immediate cause of death Congestive heart failure — Duration ?

Due to Myocardial sclerosis — ?

Due to

Other Conditions Arterial hypertension — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address Date signed M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6-28751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. 6-28751

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 173 W. Hamburg
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 173 W. Hamburg (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie Sydnor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1900

8. AGE: Years 35 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charlie Sydnor
13. Birthplace Va

MOTHER
14. Maiden Name Annie Frances
15. Birthplace Va

16 (a) Informant James Colden
(b) Address 173 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. R. Co. Md

18 (a) Funeral director Isaiah L. Brownston
(b) Address 108 W. Montgomery St

19 MAY 12 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to May 9 1945 and that I last saw h[illegible] alive on May 8 1945.

Immediate cause of death Lobar Pneumonia — Duration

Due to Cold.

Due to (over)

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James C Cayton M. D.
Address 1016 E. Sharp St. Date signed May 11 1945

G-28752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G-28752
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

6-13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman L. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Max Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Fannie Miller
(b) Address 2204 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 -1126 W North Ave

MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945 to May 10 1945 and that I last saw him alive on May 10 1945

Immediate cause of death: Acute Coronary Occlusion — Duration: about

Due to Coronary arteriosclerosis ?

Due to Cardiac Asthma — 2 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Feinglos M.D.

Address 2002 E Fayette St Date signed 5/15/45

~~38753~~ 94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 38753

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Holmes Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Nathan Talkin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name Nathaniel Talkin
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Milton H. Talkin
(b) Address 3512 Holmes Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAY 12 1945 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/1945, at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9/1945 to 5/11/1945, and that I last saw h[illegible] alive on 5/11/1945.

Immediate cause of death ! Cerebral Embolism
Cardio-Resp. failure
Due to Myocardial Insuff.
Due to Coronary Sclerosis / Myocardial degeneration } Part.
Other Conditions Bronchopneumonia, R. & Pleural Effusion
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley H. Stanley
Address Sinai Hospital Date signed 5/12/45

X

G28754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Clarinth Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Paul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Louis Paul
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fannie
15. Birthplace: Russia

16 (a) Informant: Morris Paul
(b) Address: 3720 Clarinth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 13 45 (month) (day) (year)
(c) Cemetery or crematory: Herew Washington Rd.
Location: Lansdown

18 (a) Funeral director: Sol Levinson Bros
(b) Address: 1124 W. North Ave

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 19 45 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 19 45 to 5/11 19 45, and that I last saw her alive on 5/11 19 45

Immediate cause of death	Duration
Cardio - resp failure,	
Due to Post operative complications	
Due to Due to Carcinoma	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/9/45

Major findings of operation: Secondary Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature D. d. M. Hamby M.D.
Address Sinai Hospital Date signed 5/14/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 28755 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and name town)
(d) Street No. 1224 Marden Chase Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA HARTUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Wht | 6 (a) ~~Single, married~~, widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2-1884

8. AGE: Years 60 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Geo Keller

13. Birthplace Germany

MOTHER 14. Maiden Name Luf Kuunt

15. Birthplace Germany

16 (a) Informant Louise Wedekman

(b) Address 2900 Illanois Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location York Road

18 (a) Funeral director Geo H. Lembach

(b) Address 4 N. Fremont Ave

19 (a) MAY 12 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1945, at 12:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1945 to May 11 1945, and that I last saw her alive on May 11 1945

Immediate cause of death	Duration
Acute Pulmonary Edema & heart failure	2 hrs.
Due to Hypertensive Cardiovascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl Pass M.D. M. D.

Address 4001 Wilkens Ave Date signed 5-11-45

X

Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 28756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

C 28756 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 S. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2

(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Maria Pasqua Rossi

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~if wife~~: late Alfonso Rossi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 1869

8. AGE: Years 75 | Months | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Montenero (Town, county, and state) Italy

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Camillo Rossi
13. Birthplace Italy

MOTHER
14. Maiden Name Maria G. Rossi
15. Birthplace Italy

16 (a) Informant Rose R. Rossi (Daughter)
(b) Address 302 S. Exter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1945 at 7.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1924 to 5/10 1945 and that I last saw h2. alive on 5-9-1945

Immediate cause of death: Acute Congestive Heart disease — Duration: 8 hrs

Due to: Chr. Endocarditis — Duration: 10 yrs

Due to: Chr. Arteriosclerosis — Duration: 10 yrs

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1901 Eutaw Pl. Date signed 5/14/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G-28757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Clarement St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Clarement St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Filippo Toskes

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~wife~~ late Filomena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) june 20 1871

8. AGE: Years 73 | Months 10 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Casalvecchio di Puglie Italy
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Poul Toskes
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant John F. Toskes (Son)
(b) Address 3204 E. Fairmount Ave

17 (a) Burial (b) Date thereof May 14 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St. Huntington Hillsdale Md.

19 (a) MAY 19 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed May 16 1945

VS 151

6287-58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6287-58 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Paterson N.J.
(If outside city or town limits, write RFD or name of town)
(d) Street No. 102 - 17th Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Johns Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1898

8. AGE: Years 46 Months 7 Days 11 If less than one day hr. min.

9. Birthplace New York N.Y.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew J. Johns
13. Birthplace N.J.

MOTHER
14. Maiden Name Hattie Mallete
15. Birthplace N.Y.

16 (a) Informant Lafayette Johns
(b) Address 17-17 Ave Fairlawn N.J.

17 (a) Removal (b) Date thereof 5/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn Cem.
Location Patterson, N.J.

18 (a) Funeral director Wm. J. Fralinger & Son
(b) Address No. 1 Pa. Ave. Balt. Md.

19 (a) (Date rec'd by registrar) MAY 12 1945 (b) Registrar Hunting

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1945, May 11 1945, and that I last saw him alive on 5/11 1945.

Immediate cause of death Cardiac failure — Duration

Due to N. C. V. R. Disease

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. J. Roffo M.D.
Address Mercy hospital Date signed 5/12/45

X

Physicians: please write the causes of death clearly and legibly. Entry of information upon this certificate is especially important. Be sure correct age is entered.

G28759 G28759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hampnett & List Ave.
(c) Hospital or institution:
Pine RidgeNursing Home 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3335 Ravenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE ELDRIDGE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John T. Eldridge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1880

8. AGE: Years	Months	Days	If less than one day
64	11		hr. min.

9. Birthplace White Hall, Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Alfred Wesley Sutton
13. Birthplace White Hall, Md.

MOTHER
14. Maiden Name Mary Garrett
15. Birthplace White Hall, Md.

16 (a) Informant John T. Eldridge
(b) Address 285 Oaklee Village

17 (a) Burial (b) Date thereof 5- 14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) MAY 12 1945 Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH May 9, 1945 19 at 11.5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12- 1939 to 5-9- 1945 and that I last saw her alive on 5-8- 1945

Immediate cause of death Cerebral hemorrhage with left hemiplegia — Duration 1-10-45
Due to Generalised arterio sclerosis — 1939
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Shelton C. Lacy M. D.
Address 2117 Belair Date signed 5-10-45

VS 150

Every item on information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6870

CWK-89684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 28760
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 0- 7- 29

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Bradley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Harriday

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?? 1867

8. AGE: Years	Months	Days	If less than one day
78 ??	?	?	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Major Harriday (D)
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Owens
15. Birthplace ?

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof May 12, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mr Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by Registrar) MAY 12 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1944, to May 5 1945, and that I last saw him alive on May 5 1945.

	Duration
Immediate cause of death: Bronchopneumonia	6 days
Due to: organism unknown	
Due to:	
Other Conditions: Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	7

Date of operation
Major findings of operation:
of autopsy: No pat

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. M. Phillips
Address Hadley Hosp Date signed 5-9-46

107

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6287 1/31a

Registered No. 6 28701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 N. Schroeder St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Branch.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ethel Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1881

8. AGE: Years	Months	Days	If less than one day
64	1	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Branch,
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Wheeler Branch
(b) Address 318 N. Schroeder St.

17 (a) Burial (b) Date thereof May 12, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 10 1945 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 4 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3/4 1945 to 5/8 1945, and that I last saw h[illegible] alive on 5/7 1945.

Immediate cause of death	Duration
Hypostatic Congestion	1 day
Due to —	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature [illegible]
Address [illegible] Date signed 5/10/45

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

G-28762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31a

G-28762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 E. Hoffman Street
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 E. Hoffman Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anna Wolf

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ernest A. Wolf
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) March 19, 1864

8. AGE: Years 81 | Months 1 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Emmanuel Engelbach
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Stella A. Robinson (Daughter)
(b) Address 6211 Marietta Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAY 12 1945 (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to May 10 1945 and that I last saw her alive on 5/10 1945.

Immediate cause of death: Arteriosclerotic Cardiac Degeneration — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E. Preston Date signed 5/11/45

X

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G-28763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Nursing Home 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH F. BURKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel A. Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1852

8. AGE: Years	Months	Days	If less than one day
93	0	11	hr. min.

9. Birthplace Gettysburg, Ohio
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George W. Cromer
13. Birthplace England

MOTHER
14. Maiden Name Sophia Athaus
15. Birthplace 5513 Park Heights Ave.

16 (a) Informant Mrs. Marion I. Nelson
(b) Address 5513 Park Heights Ave.

17 (a) Removal (b) Date thereof 5/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Gettysburg, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 12 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1945, at 10 05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to May 10 1945 and that I last saw her alive on May 10 1945.

Immediate cause of death	Duration
Myocarditis	
Due to Adv. Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Faerb M. D.
Address 1700 Eutaw Pl. Date signed May-11-1945

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

28764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D over

Registered No. 28764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2752 Ellicott Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Ellicott Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph T. Hopkins
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Feb 22, 1862

8. AGE: Years	Months	Days	If less than one day
82	2	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name John W. Wood
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Harry W. Hopkins
(b) Address 2752 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd & A.Co.

18 (a) Funeral director John F. Carney Inc & L. Hem
(b) Address 715 Light St.

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1945, at 6 05 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1945 to May 11 1945 and that I last saw h[illegible] alive on May 11 1945

Immediate cause of death Myocarditis — Duration about 6 Mo.
Due to
Due to
Other Conditions advanced arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold S. Hulbert M. D.
Address 2220 Harview Rd. Date signed May 12/45

(OVER)

VS 180

Please write plainly, with pen or typewriter. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G-28765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp. 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1222 Cleveland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Bauer BAUER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife C Hugo Bauer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-30-76

8. AGE: Years	Months	Days	If less than one day
68	7	11	hr. min.

9. Birthplace Germany. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Oswald Ronneberger
13. Birthplace Germany.

MOTHER
14. Maiden Name Minnad Miller
15. Birthplace Germany.

16 (a) Informant Johanna Berg
(b) Address 1222 Cleveland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Wash Blvd.

18 (a) Funeral director Ambrose Dasc
(b) Address 414 N Franklintown

19 MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11- 1945, at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1945 to 5/11 1945 and that I last saw h[illegible] alive on 5/11 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Toxic Hepatitis Hydrostatic Pneumonia	
Due to	
Other Conditions Hypertensive Cardio Vascular disease.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Hague M. D.
Address West Balt. Gen. Hospital Date signed 5/11/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

464 Registered No. G28766

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 and Wyman Park Drive
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.13 days
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Detroit
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9200 Phillips Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Albert Stern

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thelma Lubahn Stern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1913

8. AGE: Years 31 | Months 9 | Days 10 | If less than one day hr. min. 19

9. Birthplace Detroit, Michigan
(Town, county, and state)

10. Usual Occupation Second Mate

11. Industry or business Sea-faring

FATHER
12. Name Robert Stern
13. Birthplace Michigan

MOTHER
14. Maiden Name Lillie Sallheim
15. Birthplace Michigan

16 (a) Informant Records, US Marine Hospital
(b) Address Baltimore, 11, Maryland

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/12/45 (month) (day) (year)

(c) Cemetery or crematory
Location Imlay City, Michigan

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS t50

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945, to May 11 1945, and that I last saw him alive on May 11 1945.

Immediate cause of death Reticulum Cell Sarcoma — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none done

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.C. Archer M. D.

Address US Marine Hospital Balto., Md. Date signed 5/11/45

G28767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28767 Registered No.

Please write plainly with pen or pencil. Report one cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Carroll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Volkman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-5726

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 17-1872

8. AGE: Years	Months	Days	If less than one day
73	1	24	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation PRESS COTTER
11. Industry or business BALTO. BRASS Co

FATHER
12. Name WILLIAM VOLKMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name HELEN ADERMAK
15. Birthplace GERMANY

16 (a) Informant GUSTAW VOLKMAN
(b) Address 1206 CARROLL ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-45 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Cem.
Location VIOLETSVILLE MD

18 (a) Funeral director Chas G. Rohde
(b) Address 2327 Edmondson Ave

19 (a) (b) Huntington-Williams, Inc.

MAY 12 1945
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 19 45, at 3:55 P M

21. I certify that I took charge of the remains described above, held an Inquest - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 5/12/45

X

6-28768

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 166 Registered No. 6-28768

CERTIFICATE OF DEATH

Type or print the causes of death clearly and legibly. Use only black ink. Please write distinctly. Any illegible, incomplete, or incorrect entry will delay registration.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County Bladen
(c) City or town Lumberton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Dowless

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Bladen Co., N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Shipyard

FATHER
12. Name ? Dowless
13. Birthplace Bladen Co., N.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Peacock Funeral Home
(b) Address Bladenboro, N.C.

17 (a) Removal (b) Date thereof 5-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bladenboro, N.C.
Location Bladenboro N.C.

18 (a) Funeral director Wellons Brooks Inc.
(b) Address 1217 St. Paul St
Huntington Williams, Mgr.

19 MAY 12 1945 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9- 1945, at 9.30 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot of chest involving lung.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-9-45 at 8.35 P. M.
(b) Where did injury occur? 1215 Fourth Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - pistol.

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 5-10-45

VS 151

#22 to be completed

G28769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G28769

1. PLACE OF DEATH: Lake Drive Apts.
(a) Baltimore City, Maryland
(b) Street address Lake Drive Apt
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Drive Apt
(If rural give location)
Lake Drive + Pimlico ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah S. Hecht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9th 1864

8. AGE: Years	Months	Days	If less than one day
81		2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business none

FATHER
12. Name Meyer Stein
13. Birthplace Germany

MOTHER
14. Maiden Name Golde Walter
15. Birthplace Germany

16 (a) Informant Jacob Hecht
(b) Address Lake Drive Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Israel Friendship
Location Balto Md

18 (a) Funeral director Dove Funeral Home Inc
(b) Address 1482 Eutaw Pl

19 (a) (b) Registrar
Date filed by registrar MAY 12 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1945, to May 11 1945, and that I last saw her alive on May 10 1945.

Immediate cause of death	Duration
Fracture of Fem. Surg	
Due to	
Due to	
Other Conditions Decubitus ulcer Uraemic Coma.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 13/1
(b) Date of occurrence Jan. 21 1945 M
(c) Where did injury occur? Balto. Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no
(Specify type of place)
(e) Means of injury Fell to floor at home

23. Signature Duran Dyad M. D.
Address #316 Med. Arts Bldg Date signed May 11, 1945

For H. Bliss Kelly, by Howard J. Emmons, M.D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628770 472713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. 628770

PRINTED WRITE LEGIBLY, WITH INK. SPELLING MUST be correct. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Sahlman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Louis Sahlman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-84

8. AGE: Years 60 Months 5 Days 3 If less than one day hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name John Cain

13. Birthplace N.J.

MOTHER 14. Maiden Name Mary Mar

15. Birthplace Nova Scotia

16 (a) Informant Reeves.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5-14-45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Luck

(b) Address 5305 Harford Road

MAY 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945 at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945 to May 10 1945, and that I last saw h. m alive on May 10 1945

Immediate cause of death	Duration
Due to Cardiac Failure	
Due to Carcinoma advanced debilitation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Retroperitoneal (?Sarcoma) Tumor

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.

Address Johns Hopkins Hosp Date signed 5/11/45

VS 150

Dr. Golley

G-28771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G-28771

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Pinewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Pinewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William C. Schemm

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ruth V. Schemm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Conductor of B.& O.R.R.
11. Industry or business

FATHER
12. Name Christian Schemm
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Urich
15. Birthplace Germany

16 (a) Informant Mrs. Ruth V. Schemm
(b) Address 2814 Pinewood Avenue-14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Mroeland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to 5/10 1945, and that I last saw h alive on 5/10 1945.

Immediate cause of death Coronary Thrombosis.

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Tyler Golley M. D.
Address 5703 Harford Rd. Date signed 5/12/45

VS 150

G28772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

✓ G28772 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital ~~or institution~~: University
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 Poplar Grove (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Dole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~or wife~~ Sam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Sicily (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joe Monyo
13. Birthplace Italy

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Hosp. records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Greenmount Ave

19 (a) (b) Huntington Williams, M.D.
(Date filed by registrar)

L3 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11-1945, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10-1945 to 5-11-1945 and that I last saw her alive on 5-11-1945

Immediate cause of death	Duration
Respiratory failure	
Due to Ac. Cor. Pulmonary	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. M. Shipley M. D.
Address U. of Maryland Hosp. Date signed 5-14-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

G28773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G28773 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 N. Gilmor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Roberta Morton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1886

8. AGE: Years 58 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace West Rivr MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Baton
13. Birthplace West Rivr MD

MOTHER
14. Maiden Name Louisa Turner
15. Birthplace West Rivr MD

16 (a) Informant Lemma Boston
(b) Address 230 Gilmor

17 (a) Burial (b) Date thereof 6-14-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director George E. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williams MD
(Date rec'd by registrar)

MAY 13 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 3:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to May 10 1945, and that I last saw h alive on May 10 1945

Immediate cause of death Edwina Myocarditis — Duration 6 months

Due to

Due to

Other Conditions Ascites — 1 month

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. C. Leith M. D.

Address 1201 N. Ave Date signed May 10 1945

G-28774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G-28774 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Springhill Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Jaffe

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-44-1840

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Esther

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1841

8. AGE: Years 104 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Poland

MOTHER
14. Maiden Name Not known
15. Birthplace Poland

16 (a) Informant Hoyt Peirce
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Fort Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Baltimore St

19 (a) Filed (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1945 to 5/12 1945 and that I last saw h. alive on 5/12 1945

Immediate cause of death Cardio Resp Failure — Duration

Due to Hyp Cerebral Hemorrhage

Due to Hyp C-V Disease

Other Conditions Coronary Thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hoyt Peirce

Address Sinai Hospital Date signed 5/12/45 M.D.

AV 13166

VS 150

X

Every item should be carefully supplied, with ONE READING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28775 G28775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2860 Rayner Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County **
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2860 Rayner Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Laura Gebhart

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Walter A.Gebhart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23,1860

8. AGE: Years 85 | Months - | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Hockessin Del.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Benjamin F.Gebhart
13. Birthplace Penna.

MOTHER
14. Maiden Name Margaret A.Montgomery
15. Birthplace Del.

16 (a) Informant Miss.Margaret A.Gebhart
(b) Address 2860 Rayner Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14,1945 (month) (day) (year)
(c) Cemetery or crematory Red Clay
Location Marshalton Del.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to May 11 1945, and that I last saw h. alive on May 11 1945

Immediate cause of death: Myocarditis

Due to:

Due to: Chronic Bronchitis

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

Duration: 2 wks. / 10 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Evans M.D.

Address 612 N 40 St Date signed 5-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G28776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

G28776 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 and Wyman Park Drive
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr.7mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verne Howard Derrar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Patricia Cockerell
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1912

8. AGE: Years	Months	Days	If less than one day
32	5	24	hr. min.

9. Birthplace Mt. Carroll, Ill.
(Town, county, and state)
10. Usual Occupation PA Dental Surgeon R
11. Industry or business U.S. Public Health Service

FATHER
12. Name Albert Derrer
13. Birthplace Illinois

MOTHER
14. Maiden Name Louisa Kingary
15. Birthplace Illinois

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, 11, Md.

17 (a) Removal (b) Date thereof May 13-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. National Cem
Location Rock Island, Illinois
18 (a) Funeral director Roff C.B.M. Walters
(b) Address Poath Strickney Sts

19 (a) 13 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 1:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1945, to May 12, 1945, and that I last saw him alive on May 12 1945.

Immediate cause of death Hodgkins' Disease — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none done

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.C.Archer M. D.
Address U.S.Marine Hospital Baltimore,11,Md. Date signed 5/12/45

G-28777 Seward ✓ G-28777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Annie V Seward

3 (b) If veteran, name war

3 (c) Social Security Account No. ---

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1863

8. AGE: Years 82 Months 2 Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Seward
13. Birthplace Cambridge Md

MOTHER 14. Maiden Name Amby Unknown
15. Birthplace Md

16 (a) Informant Mrs John F Hardesty
(b) Address 214 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilson Godwin
(b) Address 1219 E Fort Ave

19 (a) 1945 (b) Date received by registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945 at 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to May 12 1945, and that I last saw h[illegible] alive on May 12, 1945

Immediate cause of death: CHRONIC MYOCARDITIS — Duration: FEB, 1945

Due to:

Due to LOBAR PNEUMONIA — FEB. 1945

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jeff F Arenz

Address 2[illegible] E Eutaw St Date signed 5/12/45 M. D.

G28778 G28778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution: Aged Women's + Aged Mens' Home 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Dorsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 5th 1867

8. AGE: Years 77 | Months 11 | Days 6 | If less than one day ____hr. ____min.

9. Birthplace Catonsville Md.
(Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for aged

FATHER
12. Name Christopher Dorsky
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Dietz
15. Birthplace Germany

16 (a) Informant Records
(b) Address Aged Women's + Aged Mens' Home

17 (a) Burial (b) Date thereof 5/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ____ (b) ____
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1945, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1944 to 5/11 1945, and that I last saw her alive on 5/10/ 1945

Immediate cause of death	Duration
Carcinoma rt. ovary.	??
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jewett M. D.
Address 11 E. Chase St., City Date signed 5/12/45.

VS 150

G-28779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G-28779

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 E 28th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E 28th
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A Cook

3 (b) If veteran, name war W

3 (c) Social Security Account No. xxx

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22. 1890

8. AGE: Years 54 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John J. G. Schuncke
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Hilscher
15. Birthplace Baltimore Md

16 (a) Informant Dr. J Anderson
(b) Address 324 E 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros
(b) Address 1217 W Fayette St

19 (a) (b)
(Date received by registrar) Registrar

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8, 1945 to May 11, 1945. and that I last saw her alive on May 11, 1945.

Immediate cause of death	Duration
Cardiac & respiratory failure	3 Days
Due to Coronary thrombosis & Chronic Bronchitis	3 days
Due to	
Other Conditions Diabetes.	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J Fitzgerald M. D.
Address 1613 E. North Ave Date signed

VS 150

94a

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G28780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106B

G28780 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE ENAMEL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Linn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Linn
13. Birthplace Ireland

MOTHER
14. Maiden Name Isabella Young
15. Birthplace Balt. Md.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1945 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Govans

18 (a) Funeral director Ella Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) May 13 1945 (Date filed by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10- 1945, at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1- 1945, to May 10- 1945, and that I last saw h[illegible] alive on May 10- 1945.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Bronchitis	10 days
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 5/11/45

X

G 28781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 28781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr. 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Macmurray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1939

8. AGE: Years	Months	Days	If less than one day
5	7	6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation pre-school
11. Industry or business

FATHER
12. Name Ralph MacMurray
13. Birthplace Jamaica

MOTHER
14. Maiden Name Ruth Butts
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ralph MacMurray
(b) Address 1316 Laurens St.

17 (a) Burial (b) Date thereof May 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Louis H. Strahan
(b) Address 6631 Windsor Mill Rd.

MAY 13 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945 to May 9 1945, and that I last saw her alive on May 9 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Pertussis encephalitis	3 days
Due to Pertussis	8 days
Other Conditions Bronchopneumonia	7 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 5-10-45

X

G-28782 G-28782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Poplar Grove St.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. Grese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Geo. H. Grese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/28/1878

8. AGE: Years	Months	Days	If less than one day
66	6	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation home duties
11. Industry or business

FATHER
12. Name Geo. R. Carr
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Alice Daniels
15. Birthplace Balto. Co. Md.

16 (a) Informant Mr. George R. Grese
(b) Address 1303 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cemy.
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

19 (a) 5-13-1945 (Date received by registrar) Huntington Williams Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to May 10 1945 and that I last saw h er alive on May 9 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardio vascular renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Isadora Shorofsky
Address 601 N. Monroe St. Date signed 5/11/45

X

G 28783 G 28783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.....

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 648 W Barre Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 648 W Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Simon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 6 1840
8. AGE: Years 55 Months - Days 3 If less than one day hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Palmer
11. Industry or business

FATHER
12. Name Washington Simon
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Harris
15. Birthplace North Carolina

16 (a) Informant Rosie Simon
(b) Address 648 W Barre Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director David L Brown Son
(b) Address 1516 W Montgomery Street

19 (a) MAY 12 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19 45, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 19 45 to May 9 19 45 and that I last saw him alive on May 8 19 45

Immediate cause of death Chronic Hypertensive Cardiac disease — Duration about 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Gaynes M. D.
Address 656 W Barre St Date signed 5/12/45

G 28784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 28784 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3467 June way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. City (b) County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. 96 South 2nd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Lynch

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Thomas Lynch

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 5. 1877.

8. AGE: Years 68 67 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace New York City N.Y. (town, county, and state)

10. Usual Occupation Home Work

11. Industry or business

FATHER
12. Name James Dougherty
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Dolan
15. Birthplace Ireland

16 (a) Informant Joseph M. Engh
(b) Address 1928 Cornelia St N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1945 (month) (day) (year)

(c) Cemetery or crematory Calvary
Location Queens County N.Y.

18 (a) Funeral director Kendall Hopkins
(b) Address 312 S. Highland Ave

(Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945 to May 13 1945 and that I last saw h[illegible] alive on May 12 1945.

Immediate cause of death Congestive Heart failure. — Duration

Due to Hypertensive Cardiovascular disease.

Due to

Other conditions Mild uremia Broncho-Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State) at M
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. B. Stevens M.D.
Address 3405 Erdman Ave Date signed 5/13/45

X

IN CASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G-28785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G-28785 Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alice D. Baskin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Remington Va (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name - Baskin
15. Birthplace Remington Va.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-1945 (month) (day) (year)

(c) Cemetery or crematory
Location Remington Va

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 201 E. 22nd St

(c) MAY 13 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to May 13 1945, and that I last saw her alive on May 12 1945.

Immediate cause of death	Duration
Myocardial degeneration	5 yrs
Due to Chr. nephritis	12 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer U. Todd M. D.
Address 735 N. Fulton Av Date signed 5/13/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28786 G-28786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Elkader Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Elkader Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon L. Schaffer

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-01-7025

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Alma E.
6 (c) If alive, give age 43. years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1904

8. AGE: Years	Months	Days	If less than one day
41	4	1	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation Advertising Manager
11. Industry or business Royal Crown Bottling Co.

FATHER
12. Name Ernest E. Schaffer
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Null
15. Birthplace Maryland

16 (a) Informant Alma E. Schaffer
(b) Address 3606 Elkader Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Linden Cem
Location Westminster Carroll Co.

18 (a) Funeral director Edward Hudson
(b) Address 2307 Linch Blvd.

19 (a) 5-13-1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945 at 6 A M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Vaughn B. McWaltney M.D. Medical Examiner.
Date signed 5/13/45

X

G-28787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G-28787 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Keyser (If outside city or town limits, write RURAL and give town)
(d) Street No. 450 - Davis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Kemp.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-15-64.
8. AGE: Years 75 | Months 7 | Days 27 | If less than one day hr. min.
9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation none.
11. Industry or business

FATHER
12. Name William Kemp.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nancy Clevedince
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Rosedale Keyser W. Va.
18 (a) Funeral director A. Reilly Slade
(b) Address 4907 York Road.
19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MAY 13 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1945 to 5-12 1945 and that I last saw him alive on 5-12 1945

Immediate cause of death acute perforated penetrating duodenal ulcer — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 5-9-45
Major findings of operation: Perforated duodenal ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Handelsman M.D.
Address Date signed 5-12-45

X

G-28788

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

G-28788 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymond
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Bruce
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Coady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hartline Rush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 10/10/1909

8. AGE: Years: 35 Months: 7 Days: If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Saw Foreman

11. Industry or business: Textile Mnfg Co

FATHER
12. Name: Thos Coady
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Yahraus
15. Birthplace: Baltimore

16 (a) Informant: Mrs F J Coady
(b) Address: 512 N Bruce

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Old Frederick Rd

18 (a) Funeral director: J. J. Fahey & Sons
(b) Address: 2308 Light St

19 (a) Registered by: Huntington Williams, M.D. Registrar
5-1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to 5/10 1945, and that I last saw him alive on 5/10 1945.

Immediate cause of death: Cardiac Decompensation — Duration:

Due to: Coronary Artery Disease & Coronary Thrombosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Robert Baedeker, M.D.
Address: West Baltimore General Hospital Date signed: 5/10/45

G 28789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 38

G 28789 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3924 Colborne Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---

(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County -------

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3924 Colborne Road
(If rural give location)

(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Clarence J. McFee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Callis

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 23, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	19	--hr. --min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Brush Department

11. Industry or business Pittsburgh Plate Glass Co.

FATHER
12. Name James H. McFee
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Virginia R. Bowdow
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Clarence J. McFee
(b) Address 3924 Colborne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAY 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MAY 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to May 11 1945 and that I last saw h.l.m. alive on May 11 1945

Immediate cause of death

Pulmonary Tuberculosis — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. McCollum M.D. M. D.

Address 332 Frederick Ave Date signed 5-12-45

X

PRINT. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G-28790 | BALTIMORE CITY HEALTH DEPARTMENT | G-28790

CERTIFICATE OF DEATH

510 | Registered No. (Wa)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins Apartments (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Walter Musgrave
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 20, 1864
8. AGE: Years 80 Months 8 Days 21 If less than one day hr. min. 22
9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James William Musgrave
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Elizabeth Hume
15. Birthplace Maryland

16 (a) Informant Dr. Geo. D. Stickeneer
(b) Address 104 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.
18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert St.
MAY 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar
MAY 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 at 5 00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1945, to May 11 1945, and that I last saw him alive on May 11 1945.
Immediate cause of death: Cardio - Respiratory failure — Duration
Due to Uremia
Due to Hypertensive Cardio-Vascular - Renal Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Elijah Gragus
Address U. M. H. Date signed 5-11-45 M.D.

X

G 28791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 28791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 S. Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL V. DENTON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Catherine E. Denton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Storekeeper

11. Industry or business Self

FATHER
12. Name - Denton
13. Birthplace

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace

16 (a) Informant Mr. H. P. Hoffman
(b) Address 2301 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 14 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to May 10 1945.
and that I last saw h alive on 5-10 1945.

Immediate cause of death: Chronic myocarditis — Duration: one 5 yr.
Due to: Arterio-sclerosis — one 5 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature J. Dan Moore M. D.
Address 3105 Belair Rd Date signed 5-11-45

VS 150

X

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G-28792

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3015 Harlem Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ETHEL B. ELLWOOD

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank J. Ellwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1893

8. AGE: Years 51 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas O. Griffin
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Georganna Parker
15. Birthplace Washington, D. C.

16 (a) Informant Mr. Frank J. Ellwood
(b) Address 3015 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 14 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 8:26 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945 to May 10 1945.
and that I last saw h[illegible] alive on May 9 1945.

Immediate cause of death: Carcinoma of Omentum — Duration 1 Mo.
Due to
Due to
Other Conditions Acute
(Include pregnancy within last months of death)
Date of operation 4-24-45
Major findings of operation: Carcinoma of Omentum with metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James T. Kenworthy M. D.
Address 324 Medical Arts Bldg. Date signed 5/14/45

VS 150

628793

473620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 628793

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 N. Rugsons Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley K Gremlocki (Gremlocker)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-43

8. AGE: Years	Months	Days	If less than one day
1	6	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Stanley Gremlocki
13. Birthplace N.J.

MOTHER 14. Maiden Name Sophie Bollant
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore City

18 (a) Funeral director John M. Weller
(b) Address 401 S. Chester Street

MAY 14 1945 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 11 1945, at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from May-10 1945 to May-11 1945 and that I last saw him alive on May-11 1945

Immediate cause of death Respiratory failure — Duration

Due to Uremia - laryngo-tracheal diphtheritis

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation 5-10

Major findings of operation Tracheotomy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Whittemore M. D.
Address JHH Date signed 5-12

VS 150

G 28794

CWK-93521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 28794 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Lowman Street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country 32 Poland

3 (a) FULL NAME Alex Wojcicki

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2-1902

8. AGE: Years	Months	Days	If less than one day
42	5	9	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Antonia Wojcicki
13. Birthplace Poland

MOTHER
14. Maiden Name Rosie ??
15. Birthplace Poland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.M. Co.
Location Anne arundel County

18 (a) Funeral director John M. Weber
(b) Address 405 S. Chester Street

19 (a) MAY 14 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11-1945 19 , at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to May 11 1945.
and that I last saw him alive on May 11 1945.

Immediate cause of death	Duration
Lobar pneumonia	5 days
Emphysema	
Due to organism unknown.	
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. M. Phillippe
Address Balt City Hosp Date signed 5-M 11-D 45

VS 150

G28795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 ✓

Registered No. G28795

Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Shields Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Chew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1888

8. AGE: Years	Months	Days	If less than one day
56	8		hr. min.

9. Birthplace Annapolis, Md.
(Town, county and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Chew
13. Birthplace Md.

MOTHER
14. Maiden Name Etta
15. Birthplace Md.

16 (a) Informant Thelma Robinson
(b) Address 1114 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 45 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 MAY 14 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 00

20. DATE OF DEATH May 12, 1945, at 12 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3-45 to 5-12-45 and that I last saw h[illegible] alive on 5-10-45

Immediate cause of death [illegible] Duration

Due to [illegible] and Cerebral

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 5-14-45

X

C-28796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C-28796

Please write the causes of death clearly and legibly. Typewrite, if convenient.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 Orchard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Weston Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1892

8. AGE: Years: 52 | Months: 9 | Days | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Weston
15. Birthplace Md.

16 (a) Informant Annie Johnson Pack
(b) Address 1636 Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAY 14 1945 (Date rec'd by registrar) (b) Huntington-Williams Mort. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1945, at 9:35 M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 5/12/45

VS 151

G-28797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9/a

Registered No. G-28797

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 65 Standebrun Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve W Lutz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-27

8. AGE: Years	Months	Days	If less than one day
17	8		hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Steve W Lutz
13. Birthplace Va.

MOTHER
14. Maiden Name Alia Booker
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co., Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Hamilton Ave.

19 (a) MAY 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10-1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1945 to 5-10 1945
and that I last saw h[illegible] alive on 5-10 1945.

Immediate cause of death	Duration
Circulatory collapse	
Due to Cardiac failure	
Due to Pneumococcal endocarditis	acute
Due to Bundle branch block	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Nathan J. Dixon
(g) Address Johns Hopkins Hospital Date signed 5/10/45

VS 150

C-49462 ✓

G-28798 G-28798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 No. Castle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard H Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/7/23

8. AGE: Years 21 | Months 10 | Days 5 | If less than one day — hr. — min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mark C. Bradley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Maurer
15. Birthplace Baltimore

16 (a) Informant Mrs. Catherine Bradley (mother)
(b) Address 1836 No. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Uzzerich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) MAY 14 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1945, to 5/12 1945, and that I last saw h.m. alive on 5/11 1945

Immediate cause of death Intestinal obstruction — Duration

Due to Intramesenteric Sarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/15/45

Major findings of operation: Intramesenteric Sarcoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles P. Sheldon Jr. M.D.
M. D.

Address Md. Gen'l Hospital Date signed 4/17/45

correct age is especially important. Physicians: please write the

G28799

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G28799

CERTIFICATE OF DEATH 52B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymond Ave + Oakland St.
(c) Hospital or institution: West Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 Maryland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Roth

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Roth

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec 7 1885

8. AGE: Years 59 | Months 5 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Bethlehem Steel

FATHER 12. Name Henry Roth

13. Birthplace Baltimore

MOTHER 14. Maiden Name Frances Schreiber

15. Birthplace Balto

16 (a) Informant Emma Roth

(b) Address 432 Maryland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14th (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location Essex

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) Date received by Local Registrar MAY 14 1945 (b) Huntington Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/45 19... at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/45 19... to 5/11/45 19...
and that I last saw h... alive on 5/11/45 19...

Immediate cause of death Respiratory failure

Due to Encephalitis

Due to Pneumonia

Other Conditions Cystitis
Possible Cancer
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A Duncan M. D.

Address W. K. & H. Date signed 5/15/45

X

G28800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Klotzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Aaron Klotzman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1859

8. AGE: Years 86 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Aaron Rothman
13. Birthplace: Russia

MOTHER
14. Maiden Name
15. Birthplace: Russia

16 (a) Informant: Aaron Klotzman
(b) Address: 4200 Carleview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-45 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: Jace Lewis Inc

18 (a) Funeral director
(b) Address: 1139 E. Balto St

19 (a) MAY 14 1945 (Date rec'd by local reg.) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945, at 11.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935, to May 13 1945, and that I last saw her alive on May 13 1945.

Immediate cause of death: Coronary thrombosis — Duration: 2 weeks

Due to:

Due to:

Other Conditions: Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis T. Lavy M. D.
Address: 1844 W. North Ave Date signed 5/14/45

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G-28801
Registered No.

Typewriter or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Rugby Road
(c) Hospital or institution: NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Rugby Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Thomas Carey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: A. Morris Carey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1869

8. AGE: Years 76 | Months 2 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name James Carey Thomas
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Whitall Thomas
15. Birthplace Phila'delphia

16 (a) Informant Mrs. Ruston McIntosh
(b) Address 4311 Rugby Road Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1945 (month) (day) (year)
(c) Cemetery or crematory Lowden Park
Location Baltimore Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) Date received MAY 14 1945 (b) Filed by Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944, to May 12 1945, and that I last saw her alive on May 11 1945.

	Duration
Immediate cause of death: Pulmonary infarct	8 days
Due to: Arteriosclerotic C.V. disease & hypertension	3-4 yrs
Due to:	
Other Conditions: Diabetes Mellitus	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature: Frances W. Kluck M. D.
Address 715 Park Ave Date signed 5/12/45

930

G-28802 1 BALTIMORE CITY HEALTH DEPARTMENT G-28802

CERTIFICATE OF DEATH 122B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 East 20th St., City
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Chenowith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wm. E. Chenowith
6 (c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) Feb. 16, 1863
8. AGE: Years 82 Months 2 Days 26 If less than one day ..... hr. ..... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Wm. Grover
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Martin
15. Birthplace Maryland

16 (a) Informant Wm. Chenowith
(b) Address 1118 East 20th St., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory St. John's Lutheran
Location Putty Hill - Balto. Co., Md.

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 N. Mt. Royal Ave.

19 (d) MAY 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945, to May 11 1945, and that I last saw h.er alive on May 11 1945.

Immediate cause of death: Cardiorespiratory failure — Duration
Due to: Generalized arteriosclerosis
Due to: Hypertensive cardiovascular disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation: May 3, 1945
Major findings of operation: Intestinal obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. K. Lawrence M. D.
Address Union Mem'l Hosp. Date signed 5/11/45

PRINT WITH PEN AND INK. Every item of information should be carefully supplied. Use UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1 X

G 28803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

Registered No. G 28803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Winston avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Govans
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Winston avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS LEO FAHEY

3 (b) If veteran, name war -----

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mary Mullin Fahey
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1881

8. AGE: Years	Months	Days	If less than one day
64	1	23	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Restaurateur
11. Industry or business

FATHER
12. Name Michael P. Fahey
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Banaghan
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Mullin Fahey
(b) Address 816 Winston avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. L. Evans. Son Inc
(b) Address 118 N. Mt Royal Ave

19 (a) (Date rec'd by Registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 9.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1943 to May 11, 1945, and that I last saw h in alive on May 11th 1945.

Immediate cause of death Exhaustion — Duration 2

Due to Carcinoma of Larynx. — Duration 2½ yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Ross.
Address 28 W 25th St. Date signed 5-12-45 M. D.

VS 150

G 38804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G 38804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 NORTH CALVERT STREET.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town CITY BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 N. CALVERT STREET
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL J. WHEELER.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 705-07-4952

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Bertha Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1869

8. AGE: Years 75 | Months 6 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired Asst. Signal

11. Industry or business Supt.

FATHER
12. Name Samuel J. Wheeler
13. Birthplace Penna.

MOTHER
14. Maiden Name Rebecca Whelen
15. Birthplace Unknown

16 (a) Informant Mrs. Bertha Winter
(b) Address 2513 N. Calvert street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas J. Cragg Son Inc
(b) Address 1148 W. Mt. Royal Ave, Baltimore, Md.

19 (a) MAY 14 1945 (Date rec'd by registrar) (b) Huntingtor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 1945 19 , at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 9 1945 to MAY 11 1945, and that I last saw him alive on MAY 11 1945.

Immediate cause of death	Duration
CARCINOMIA OF STOMACH FEB	1945.
Due to CHRONIC MYOCARDIAL DEGENERATION	1945.
Due to ARTERIOR SCLEROSIS	1945.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas J. Cragg M. D.
Address 3015 ST PAUL ST Date signed MAY 1

VS 150

Every item of information should be carefully worked out. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G28805

CWK-89922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G28805

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 7- 18

(e) Length of stay in Baltimore (yrs., mos., or days) 16- 8- 26

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 821 N. Arlington Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Charles Colbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15-1928

8. AGE: Years	Months	Days	If less than one day
16	8	26	hr. min.

9. Birthplace Baltimore-Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Colbert

13. Birthplace Maryland

MOTHER

14. Maiden Name Hazel Taft

15. Birthplace Pennsylvania

16 (a) Informant Records, Balto. City Hospitals

(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof 5-15-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) MAY 14 1945 (b)

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 11- 1945, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1944, to May 11 1945, and that I last saw him alive on May 11 1945.

Immediate cause of death (a) Pulmonary Tuberculosis — Duration 1 yr.

Due to

Due to

Other Conditions Diabetes mellitus — 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harold Kelbon M. D.

Address Balto City Hosp. Date signed 5/12/45

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-28806 G-28806

BALTIMORE CITY HEALTH DEPARTMENT 93D Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alan F. Benjamin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1868

8. AGE: Years 76 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bethlehem Fairfield Co.

FATHER
12. Name Alfred J. Benjamin
13. Birthplace Md.

MOTHER
14. Maiden Name Aline Nesbitt
15. Birthplace Pa.

16 (a) Informant Albert F. Benjamin
(b) Address Minneapolis Minn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16 45 (month) (day) (year)
(c) Cemetery or crematory Parsons Cem.
Location Salisbury, Md.

18 (a) Funeral director John Orsatelli & Sons
(b) Address 1908 Eutaw Place

19 MAY 1 6 1945 (Date rec'd by local reg.) (b) Hunting Town Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13- 1945 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1945 to 5-13- 1945 and that I last saw h/m alive on 5-13- 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 wks.
Due to: Arteriosc. C-V. Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Perlee

Address 213 Light St. Date signed 5-13-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 2880 G 2880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3815 Ellerslie Ave St., 9-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 19 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Herbert Fogan

If U. S. Veteran specify WAR

(a) Residence: No. 3815 Ellerslie Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) December 25, 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	4 5	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Never Worked

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

FATHER

13. NAME Robert Hinton Fogan

14. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

MOTHER

15. MAIDEN NAME Ann Caroline Clotworthy

16. BIRTHPLACE (city or town)
(State or country)

17. INFORMANT Miss Lillian Dunham
(Address) 3815 Ellerslie Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Olivet Date May 15 19 45

19. UNDERTAKER John O. Mitchell & Sons
(Address) 1900 Eutaw Place

20. FILED 19 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 13, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 11, 1945, to May 13, 1945

I last saw him alive on May 13, 1945. Death is said to have occurred on the date stated above, at 12:20 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	5/11/45
Other contributory causes of importance: Arteriosclerosis	
Optic Atrophy	1885

Was an operation performed? Yes Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) W. Grafton Harperger M. D.

(Address) 21 W Medical Arts Bldg

SEE CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V8 3

MAY 14 1945 Registrar for Baltimore, Md.

X

ALVERIA

G28808

BALTIMORE CITY HEALTH DEPARTMENT ✓ G28808

CERTIFICATE OF DEATH 830

Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. PRINTED NAMES, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1347 Gorsuch Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverna F. Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Lehman E. Davis

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1898

8. AGE: Years 57 | Months 3 | Days 4 | If less than one day hr. min. 188

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lehman F. Hollsinger

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth King

15. Birthplace Md

16 (a) Informant Mrs Lehman E. Davis

(b) Address 1347 Gorsuch Ave

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Ballinger Md.

18 (a) Funeral director F. B. Herbert & Son

(b) Address 300 Eastern Ave

19 (a) Huntington Williams, M.D.
(Date rec'd by Registrar) 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945; at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to May 9 1945 and that I last saw h alive on May 9 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 6 hrs

Due to Essential Hypertension — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Novak

Address 101 W. Read St. Date signed 5-10-45 M.D.

G28809 | BALTIMORE CITY HEALTH DEPARTMENT | 46H | G28809

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Agnes Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Belgian Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Burhorst

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Female	White	Married

6 (b) Name of ~~husband~~ or wife Edward H.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 12 1896

8. AGE: Years	Months	Days	If less than one day
48	5	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name John Wahbel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Koestner
15. Birthplace Baltimore Md

16 (a) Informant Edward H Burhorst
(b) Address 808 Belgian Ave
17 (a) Burial (b) Date thereof 5/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave
18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St
19 (a) (Date rec'd by registrar) MAY 14 (b) 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 at 7.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1945 to May 11 1945 and that I last saw h~~er~~ alive on May 11 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Pelvic Peritoneal malignant Paraganglioma	
Due to	
Other Conditions Metastatic Spinal	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas L. Cox Jr. M. D.
Address St Agnes Hosp Date signed 5/11/45

VS 150

~~Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.~~

G28810 G28810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Asburton St.
(c) Hospital or institution:
West Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 30Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Franklintown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry N. Boylan (Boylan)

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. 705-12-3242

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1894

8. AGE: Years	Months	Days	If less than one day
50	9	10	hr. min.

9. Birthplace Harrisonburg Va. (Town, county, and state)

10. Usual Occupation Tinner

11. Industry or business Roofing

FATHER
12. Name James M. Boylan
13. Birthplace Va.

MOTHER
14. Maiden Name Rose E. Bell
15. Birthplace Va.

16 (a) Informant Kenneth K. Boylan
(b) Address 827 N. Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. County Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by reg.) (b) Huntington for Wilkens

VS. 10M 1 4 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1945, at 1:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCallum M.D. Medical Examiner
Date signed 5/13/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G28811

28811

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave + Dukeland St.
(c) Hospital or institution West Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural Essex.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Garden Drive, Marlin Gardens
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minna Lindenberger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ John M. Lindenberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	20	- hr. - min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Louis Rebbel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Estrup
15. Birthplace Germany

16 (a) Informant Henry Lindenberger (Son)
(b) Address 915 Garden Drive Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

19 (a) MAY 14 1945 Huntington Williams M.E. (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

7:25 PM

20. DATE OF DEATH 5/13/45 19 , at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12/45 19 , to 5/13/45 19 , and that I last saw h.m. alive on 5/13/45 19

Immediate cause of death Respiratory failure

Due to Cerebral Accident

Due to Hypertension Cardio Vascular disease

Other Conditions Mild Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Duncan M. D.
Address W. B. G. H. Date signed 5/12/45

X

G28812

BALTIMORE CITY HEALTH DEPARTMENT 93D

CERTIFICATE OF DEATH

G28812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 Webster St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 Webster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L. Oliver

3 (b) If veteran, name war No.
3 (c) Social Security Account No. No.

4. Sex Male.
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1887

8. AGE: Years 58 Months 2 Days 25 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired - Grain
11. Industry or business Trimmer

FATHER
12. Name Joseph Oliver
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Haskill
15. Birthplace N. C.

16 (a) Informant Elizabeth Miller
(b) Address 1327 Andre Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Annapolis Blvd.

18 (a) Funeral director Chas. J. Dill.
(b) Address 1501 E. Fort Ave.

19 (a) MAY 14 1945 (Date received by local registrar) (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1945 to 5-10 1945 and that I last saw him alive on 5-9 1945

Immediate cause of death Chronic Myocardial Degeneration — Duration 6 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ballard M. D.
Address 201 E. Fort Ave. Date signed 5-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G28813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Matilda Wolfermann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1881

8. AGE: Years 63 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name John Wolfermann
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Sink
15. Birthplace Germany

16 (a) Informant Mr. Wm Wolfermann
(b) Address 436 N. Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Linden Lane

18 (a) Funeral director P. J. Neumann & Son
(b) Address 1225 E. Broadway.

19 (a) MAY 14 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1945, 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1936, to May 12 1945, and that I last saw h alive on 19.

Immediate cause of death — Duration
Hypertension Cardio Renal Disease — 9 years.
Due to
Due to
Other Conditions
Toxemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

5 hrs.
PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert E. Schmidt M. D.
Address 3939 Fremont Ave Date signed 5/13/45

VS 150

X

Entries must be made in PERMANENT BLACK INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. G28814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BROADWAY & FAIRMOUNT AVE
(c) Hospital or institution:
CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 562 9 ANTHONY AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ZWICKER, MRS. MARIE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FE	WHITE	WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) DEC. 3, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	9	— hr. — min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation MINE
11. Industry or business

FATHER
12. Name GEORGE DIETZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name CHRISTINA FLACK
15. Birthplace GERMANY

16 (a) Informant MRS. MARIE JONES
(b) Address 562 9 ANTHONY AVE.

17 (a) Burial (b) Date thereof MAY 15, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director L. HECKMANN'S SON
(b) Address 37 S. BROADWAY

19 (a) MAY 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 11, 1945, to May 12, 1945, and that I last saw her alive on May 12 1945.

Immediate cause of death	Duration
Myocardial infarction	
Due to Coronary occlusion	
Due to Arteriosclerotic Cardiovascular disease	
Other Conditions Strangulating umbilical hernia	

(Include pregnancy within 3 months of death)

Date of operation May 12 1945

Major findings of operation: Strangulating umbilical hernia, adominal adhesions

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steven Hatch M. D.
Address C. H. H. Date signed 5-14-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G28815 — BALTIMORE CITY HEALTH DEPARTMENT — G28815 Registered No.

CERTIFICATE OF DEATH

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Whitehall (If outside city or town limits, write RURAL and give town)
(d) Street No. RFD (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Hannah Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife David H. Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	10	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Richard J. Evans
13. Birthplace Wales

MOTHER
14. Maiden Name Anna Davies
15. Birthplace Wales

16 (a) Informant Mrs. Hughes
(b) Address Whitehall, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1945 (month) (day) (year)
(c) Cemetery or crematory Lutheran
Location Felton Pa.

18 (a) Funeral director Gilbert R. Parkin
(b) Address Felton Pa.

19 (a) (Signature of registrar) (b) MAY 14 1945 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1945, at 3 15/A M

21. I certify that death occurred on the date above stated: that I attended deceased from 5-12 1945 to 5-14 1945 and that I last saw her alive on 5-14 1945.

Immediate cause of death Anuria — Duration

Due to Diabetes mellitus

Due to

Other Conditions Arteri-sclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Humpstrey Jr. M. D.
Address 332 E. University Pkwy Date signed 5-17-45

X

G 28816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 a

G 28816 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1348 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Same
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Cornelius White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alice White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 - 1887

8. AGE: Years 57 | Months 9 | Days 9 | If less than one day: hr. min.

9. Birthplace Chestertown Md
(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name Jervis White
13. Birthplace Maryland

MOTHER
14. Maiden Name Bessie Lively
15. Birthplace Maryland

16 (a) Informant Alice C. White
(b) Address 1348 N. Calhoun

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 5-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Jas Geo H. Holland
(b) Address 1631 Edmondson Ave

19 (a) MAY 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1945, at 12 38 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937, to May 1945, and that I last saw h.i.m alive on May 10 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	
Due to	
Other Conditions Hemiplegia from Previous Cerebral Hemorrhage	7 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglass Shepperd M. D.
Address 1663 Myrtle Ave Date signed 5/14/45

X

M. D. B. 1268-9

G28817

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28817

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 516 W. Lee St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 2 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Mary Rears

(a) Residence: No. 516 W. Lee St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Meade Rears

6. DATE OF BIRTH (month, day, year) February 4, 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	3	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Lawrenceville Va. (State or country) Brunswick Cnty

FATHER

13. NAME Henry Peoples

14. BIRTHPLACE (city or town) Lawrenceville Va (State or country) Brunswick Cnty

MOTHER

15. MAIDEN NAME Betty

16. BIRTHPLACE (city or town) Lawrenceville Va (State or country) Brunswick Cnty

17. INFORMANT Lillian V. Patterson

(Address) 516 West Lee St Baltimore 30 Md

18. BURIAL, CREMATION, OR REMOVAL

Empora Greenville Cnty Va Date May 15, 1945

19. UNDERTAKER Joseph A. Sisly

(Address) 4699 W Mount Holly St Baltimore, Md

20. FILED 19

Huntington White Registrar

MAY 14 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 11, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 3, 1945, to May 11, 1945.

I last saw her alive on May 11, 1945. Death is said to have occurred on the date stated above, at 9 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	3 days

Other contributory causes of importance:

Hypertension	

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) W. Donald Bando M. D.

(Address) 2445 D Hill Ave, Balto 17 Md.

V. S. 3

OCCUPATION is very important. See instructions on back of certificate. Exact statement of occupation of women in home must be given, so that it may be properly classified.

28818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#64

Registered No. 28818

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon B. Ames

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna E. Ames
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20-1880

8. AGE: Years 65 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Accomac Co. Va
(Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Elijah Ames
13. Birthplace Accomac Co. Va

MOTHER
14. Maiden Name Vandalia Mears
15. Birthplace Accomac Co. Va

16 (a) Informant Mrs Anna E. Ames
(b) Address 1408 Eutaw Place

17 (a) Burial (b) Date thereof 5-14-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) MAY 14 1945 (Registrar) Interring for Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 7 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to May 11 1945, and that I last saw h. I. M. alive on May 11 1945.

Immediate cause of death	Duration
Retroperitoneal Squamous Cell Carcinoma	5 Mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. N. Mclaire
Address 617 W. 40th St Date signed 5/12/45 D.

G28819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G28819

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Direct age is especially important. Physicians: please write PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave
(c) Hospital or institution: German Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander W. Mitlocknes

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION 11 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Elizabeth Boch
6 (c) If alive, give age years

20. DATE OF DEATH May 11/45. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8/45 19 May 11/45 19 and that I last saw him alive on May 8/45.

7. Birth date of deceased (mo., day, yr.) Nov 4, 1863

8. AGE: Years	Months	Days	If less than one day
81	6	8 7	hr. min.

Immediate cause of death — Duration

Broncho Pneumonia 10 days.

Due to

Due to

Other Conditions Unknown.

Arterio Sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Joseph Mitlocknes
13. Birthplace Austria
14. Maiden Name Fraciska Walkingscheck
15. Birthplace Austria

16 (a) Informant Genl German Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry N Weitzel
(b) Address 4101 E Lemmondson Ave.

19 (a) 1945 Date rec'd by registrar Huntington Williams M.D. Registrar

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Harris Stamm
Address 93 D Haven Date signed May 12/45

VS 150

6'8820 X V 6'8820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Poh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ernest.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1894

8. AGE: Years	Months	Days	If less than one day
50	6 7	2 3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Carl PFEIFLE
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Schuster
15. Birthplace Germany

16 (a) Informant Mr. Ernest Poh
(b) Address 4103 Wilkens Ave.

17 (a) Burial (b) Date thereof 5/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3200 Frederick Rd

18 (a) Funeral director Harry H Wiltse
(b) Address 4101 Edmondson

19 (a) 5-14-1945 (b) Livingston Williams, Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 19 45 at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 19 45 to 5/10 19 45, and that I last saw h[illegible] alive on 5/10 19 45.

Immediate cause of death	Duration
Sarcoma of uterus	
Due to	
Due to	
Other Conditions none known	

(Include pregnancy within 3 months of death)

Date of operation 4/18/45
Major findings of operation: Sarcoma of uterus
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stur
Address St Agnes Hospital Date signed 5/10/45 M/D.

VS 150

X

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-88821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

466 Registered No. G-88821

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 Union Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 Union Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Malinda Noland.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife Charles J. Noland.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1864

8. AGE: Years	Months	Days	If less than one day
81	2	15	hr. min.

9. Birthplace Silver Grove W. Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Grove.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Virginia E. Everhart.
15. Birthplace W. Va.

16 (a) Informant Mrs. Elsa Reviol.
(b) Address 832 Union Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave
18 (a) Funeral director Chadwick & Donovan
(b) Address 3615 Chestnut Ave

MAY 14 1945 (Date rec'd by registrar)
(b) MAY 14 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1945 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1940 to 5/13 1945
and that I last saw her alive on 5/12 1945

Immediate cause of death: Carcinoma Pelvic Organs – (Colon)
Due to
Due to
Other Conditions Myocarditis, Chr. Cerebral Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hilton Richards M. D.
Address 321 Druid Hill Date signed May 13 1945

VS 150

G-28822 G-28822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E + Calvert
(c) Hospital or institution: Union Memorial 6 days 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Linden ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry William Lyon
3 (b) If veteran, name war --
3 (c) Social Security Account No. 231-10-0984
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married.
6 (b) Name of husband or wife Emma D. Lyon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-12-80
8. AGE: Years 65 Months 3 Days — If less than one day hr. min.
9. Birthplace Md. (Baltimore) (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business Balto. I. P. Co.
FATHER 12. Name Henry W. Lyon
13. Birthplace Md (Balto.)
MOTHER 14. Maiden Name Catherine Eberlein
15. Birthplace Balto., Md.
16 (a) Informant Mr. Frank Lyons
(b) Address 504 Murdock Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem. Balto., Md.
Location
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945 at 8:15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1945 to 5-12 1945 and that I last saw h.i.m alive on 5-12 1945

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Myocardial infarct	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William H. Triplett M. D.
Address Union Memorial Hosp. Date signed 5-12-45

VS 150 MAY 14 1945

G28823 G28823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 2722 Auchentoroly St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 22 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Kell Lucas — If U. S. Veteran specify WAR

(a) Residence: No. 2722 Auchentoroly Terrace St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edith Atkinson Lucas

6. DATE OF BIRTH (month, day, year): March 24 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	1	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Accountant

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Hardware, Plumbing

10. Date deceased last worked at this occupation (month and year): March, 1944

11. Total time (years) spent in this occupation: 15 years

12. BIRTHPLACE (city or town) (State or country): Baltimore Maryland

FATHER

13. NAME: Francis Lucas

14. BIRTHPLACE (city or town) (State or country): Baltimore Maryland

MOTHER

15. MAIDEN NAME: Elizabeth Anne Layfayette

16. BIRTHPLACE (city or town) (State or country): Carroll County Maryland

17. INFORMANT: Miss Dorothy Lucas

(Address) 2722 Auchentoroly Terrace

18. BURIAL, CREMATION, OR REMOVAL

Place: Loudon Park Date: 5/15/45 19

19. UNDERTAKER: WM. J. TICKNER & SONS

(Address) Balto., Md.

20. FILED 19 Huntington Wilson, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): May 13, 1945

22. I HEREBY CERTIFY, That I attended deceased from January, 1944, to May 13, 1945

I last saw him alive on May 8, 1945. Death is said to have occurred on the date stated above, at 1:20 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Cardio-Vascular Renal Disease	1942

Other contributory causes of importance: None

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. Grafton Hersperger M. D.

(Address) 214 Medical Arts Bldg.

OCCUPATION is very important. See instructions on back of certificate.

VS 3

MAY 14 1945

G 28824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 28824 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 N. Calvert St.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EMMA C. MARTIN

3 (b) If veteran, name war: None

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: William M. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1858

8. AGE: Years	Months	Days	If less than one day
86	4	19	hr. min.

9. Birthplace Lewistown, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George W. Green
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Weller
15. Birthplace Md.

16 (a) Informant Mrs. Gladys K. Martin
(b) Address 2923 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 1618 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to May 12, 1945, and that I last saw h.er alive on May 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to Arterio-sclerosis

Due to

Other Conditions Chronic Endo-Carditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. Buchanan M. D.
Address 1651 Caddox St. Date signed 5/12/45.

X

CAUTION—WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 28825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G 28825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Memorial Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5803 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Holt Hutchinson

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Elsie Hutchinson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 15 1869

8. AGE: Years	Months	Days	If less than one day
75 76	6	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Francis Hutchinson
13. Birthplace Easton Pa.

MOTHER
14. Maiden Name Sarah Seibold
15. Birthplace Pa. (New Berlin)

16 (a) Informant Mr. Malcolm Hutchinson
(b) Address 3800 Clifton Ave.

17 (a) Burial (b) Date thereof 5/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1945, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1945 to 5-12 1945 and that I last saw him alive on 5-12 1945

Immediate cause of death Cardio-resp collapse. — Duration

Due to GI Hemmorhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Musgrave Jr. M. D.
Address 322 E. Lemmony Place Date signed 5/13/45

VS 150

G28836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G28836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4417 Belvieu Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4417 Belvieu Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE G. HILGARTNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Florence M. Hilgartner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Sect.
11. Industry or business Traders Saving & Loan

FATHER
12. Name Henry Hilgartner
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Most
15. Birthplace Germany

16 (a) Informant Leonard H. Hilgartner
(b) Address 33 Edmondsonridge Rd., Catonsville 28

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 150 MAY 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 12 1945, and that I last saw h alive on May 12 1945.

Immediate cause of death: Cerebral Apoplexy — Duration: 2 hrs.
Due to: Arteria sclerosis — Duration: several yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Bauman Rood M. D.
Address 2200 Garrison Blvd Date signed 5-14-45

X

G 288:27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G 288:27 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 N Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 North Dallas (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS CRUMLEY (Thomas M. Crumley)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 30, 1945

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas E. Crumley
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Margaret Raab
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Margaret Crumley
(b) Address 1806 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Balto Md

18 (a) Funeral director George J. Keith Inc
(b) Address 1735 Hartford ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12/45 19.., at 12:22 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dehydration
Acidosis

Due to

Other Conditions (coma)

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 5/13/45

Please write the causes of death clearly and legibly. Physicians: please write the

28828 CWK-92417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 28828

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 yrs. 2 mos. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Trinity Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Romano

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Louise ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1860 ?

8. AGE: Years	Months	Days	If less than one day
84 ?			hr. min.

9. Birthplace Constantinople
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace Constantinople

MOTHER
14. Maiden Name ? Dominick
15. Birthplace Constantinople

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Disposal Burial (b) Date thereof 5/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. Md

18 (a) Funeral director Frank Pelly Vace
(b) Address 5[illegible] N. Wolfe St

19 (a) MAY 14 1945 (b) Hunter Jr. Williams, M.D.
(Date Rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 45 at 3:45 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 5 19 45 to May 12 1945, and that I last saw him alive on May 12 1945.

Immediate cause of death	Duration
Carcinomatosis - Primary site unknown	?
Due to	
Due to	
Other Conditions generalized arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Pillsbury M.D.
Address Baltimore Md Date signed 5-13-45

VS 130

628829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 628829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5313 Edmondson Ave
(b) Street address ~~3206 Ingleside Ave.~~
(c) Hospital or institution: Hoed Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Ingleside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine R Bohrmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29 - 1856

8. AGE: Years 89 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace California (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Charles Kohler

13. Birthplace Germany

MOTHER 14. Maiden Name Elise Krogen

15. Birthplace Germany

16 (a) Informant Mrs Benjamin F Gruteus

(b) Address 3206 Ingleside Ave

17 (a) Cremation (b) Date thereof May 14-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

18 (a) Funeral director Chas D Powell

(b) Address 2427 Edmondson Ave

19 (a) (Date received by local registrar) MAY 14 1945 (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to May 13 1945 and that I last saw h alive on May 12 1945.

Immediate cause of death	Duration
(a) Uremia Coma Stomach Cancer	2 weeks
Due to (b) Generalized Arterio	5 yrs
Due to (c) Pellagra	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas D Powell

Address 415 Frederick Ave Date signed 5/14

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 15 7E

G28830

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Fenton
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County ~~Baltimore~~ Baltimore English Count
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Rose Ave. # 27
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacqueline Ruane

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 - 1943

8. AGE: Years	Months	Days	If less than one day
	2	1	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name John Ruane
13. Birthplace Scranton Pa.

MOTHER
14. Maiden Name Mildred Old
15. Birthplace Steelton Pa.

16 (a) Informant Mr. John Ruane
(b) Address 2817 Rose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 (a) Date received MAY 1 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1945 at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 5/1 1945 and that I last saw her alive on 5/1 1945

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to	
Due to	
Other Conditions Congenital Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel
Address Md. Gen'l Hospital Date signed 5/1/45 D.

107

G28831

JL - 93523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G28831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1016 W. Fayette St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. , 1885

8. AGE: Years 60 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jim Hall
13. Birthplace N. C.

MOTHER
14. Maiden Name Jane McCallister
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof May 14, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder St

19 (a) [illegible] 1945 Huntington Hill Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8, 1945 to May 10 1945 and that I last saw him alive on May 10 1945

Immediate cause of death	Duration
Abscess of the lung	
Due to Confluent lobar pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: a. above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Lin Edmund M. D.

Address City Hospitals Date signed 5-12-45
Balto. Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 28832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 28832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Grunst
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tyrone Md
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Hamner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years 20 | Months - | Days - | If less than one day ... hr. ... min.

9. Birthplace Carroll Co, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Walter S Hamner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Wantz
15. Birthplace Maryland

16 (a) Informant Walter S Hamner
(b) Address Westminster Md R.F.D

17 (a) Burial (b) Date thereof May 17-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Valley Cem
Location Pleasant Valley Md

18 (a) Funeral director D. D. Hamilton & Son
(b) Address Union Bridge & New Windsor Md

19 (a) MAY 14 1945
(Date rec'd by registrar)
Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 14 1945, and that I last saw h alive on 2.20 P.M.

Immediate cause of death The - pneumonia — Duration

Due to

Due to

Other Conditions Progressive muscle dystrophy
(Include pregnancy within 3 months of death)

Date of operation May 16, 1945

Major findings of operation: Acute dilatation of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Miles E Drake M. D.

Address Union Hosp. Date signed 5-14-45

VS 150

G28833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G28833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Afonso Jackson or (Alphonso Jackson)

3 (b) If veteran, name war — WWI

3 (c) Social Security Account No. 214-16-845

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Jackson

6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name William Jackson
13. Birthplace Pa.

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Elizabeth Jackson
(b) Address 1020 N. Wolfe st

17 (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Natl
Location.....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) MAY 14 1945 (b) Huntington for William M.
(Date rec'd by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11-1945, at 10-15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Gunshot of Heart & lung
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-11-45 at 10.30 P.M.
(b) Where did injury occur? Street, inside 1020 N. Carlton St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm - revolver

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 5-12-45

write the causes of death clearly and legibly. Physicians: Please write

628834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 628834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Edmondson ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Edmondson ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William J. Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Stewartown, Kingston, Jamaica
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Kingston, Jamaica

MOTHER
14. Maiden Name Susan Cunningham
15. Birthplace Kingston, Jamaica

16 (a) Informant William J. Hill
(b) Address 1010 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) MAY 14 1945 (Date rec'd by Registrar) (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10/45, at 5:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to 10 1945 and that I last saw h[illegible] alive on May 10 1945

Immediate cause of death Coronary Occlusion

Due to Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas J Henderson M. D.
Address 1202 Dean St Date signed 5-12-45

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G28835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28835 Registered No. 38Σ

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 - Forman Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacqueline Hewlin
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 19, 1944
8. AGE: Years | Months 11 10 | Days 23 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Samuel Hewlin
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Shipland
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5-15-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1343 Presstman St

MAY 14 1945 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1945 at 9 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1945 to 5-12 1945 and that I last saw h.e alive on 5-12 1945

Immediate cause of death: Septicemia
Antecedent to
Due to Chicken-pox
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren M. Quigley M.D.
Address JHH Date signed 5-12-45

X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

G28836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G28836
Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua B. Colvin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Manufacturer
11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Ralph Colvin
(b) Address 1811 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-45 (month) (day) (year)
(c) Cemetery or crematory Chet Rhylom
Location O'Donnel St

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E. Balto St

19 (a) 1945 (Filed by registrar) (b) Huntington Williams Jr

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1945 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1945 to 5/12 1945 and that I last saw h[illegible] alive on 5/12 1945

Immediate cause of death	Duration
Coronary Thrombosis	20 min.
Due to Arteriosclerosis Heart disease	
Due to	
Other Conditions Rheumatic Heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Blum M.D.
Address 2310 Eutaw Pl. Date signed 5/14/45

VS 150

G28837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G28837 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1851

8. AGE: Years 94 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham Lyth
13. Birthplace

MOTHER
14. Maiden Name Rachel
15. Birthplace Lith

16 (a) Informant Ethel Greenfield
(b) Address 3203 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philp Rd & Rowley La

18 (a) Funeral director Jack Lewis Jr
(b) Address 1807 E Baltimore St

1945 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 12:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31 1938 to 5-14 1945
and that I last saw h alive on 5-14 1945

Immediate cause of death Cerebral Arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin, M.D.
Address Levindale Date signed 5/14/45

VS 150

X

G28838

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28838

CERTIFICATE OF DEATH 53

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4011 Old York Rd St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 83 yrs. mos. da. | How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Rozella McKay 9'

If U. S. Veteran specify WAR.

(a) Residence: No. 4011 old York Rd St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John J. McKay

6. DATE OF BIRTH (month, day, year) Jan 29, 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Richmond, Va

FATHER

13. NAME William Henry Berry

14. BIRTHPLACE (city or town) (State or country) Richmond Va

MOTHER

15. MAIDEN NAME Alexander Megginby

16. BIRTHPLACE (city or town) (State or country) Richmond, Va

17. INFORMANT Daughter Miss Ruth McKay

(Address) 4011 old York Rd

18. BURIAL, CREMATION, OR REMOVAL

Place London Park Date May 16 1945

19. UNDERTAKER Wilson Funeral Home

(Address) 1219 N Paul St

MAY 14 1945

21. [illegible] Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 13, 1945

22. I HEREBY CERTIFY, That I attended deceased from Sept, 1935 to May 1945

I last saw her alive on May 13, 1945 Death is said to have occurred on the date stated above, at 6.50 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Stomach probable	1944 ca.

Other contributory causes of importance:

General Debility	

Was an operation performed? No Date of

For what disease or injury?

Name of operation — No

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) Lyman S. Elliott M. D.

(Address) 3939 Greenmount

OCCUPATION is very important. See instructions on back of certificate.

V8 3

X

G288839 — Letter X — G288839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Louisiana Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth L. Letton

3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife August F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19. 1890

8. AGE: Years 54 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name H. Schenfeld
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Harry Letton
(b) Address 2928 Louisiana Ave Baltimore

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Pilliom Funeral Home
(b) Address 1217 Ft Street

19 (a) (Date received by registrar) MAY 14 1945 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13- 1945, at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30- 1945 to 5-13- 1945, and that I last saw her alive on 5-13- 1945

Immediate cause of death Respiratory Failure — Duration

Due to Hemorrhage & Weakness

Due to Carcinoma of Cervix with metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth W Baldwin M. D.
Address West Baltimore General Hosp Date signed 5/13/45

X

CERTIFICATE WRITTEN PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28840 — Dr Omicha South Baltimore Gen'l — G28840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No. 7127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2534 East Eagan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

7-V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 E. Eagan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Sligh

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex Male — 5. Color or race White — 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9. 1859

8. AGE: Years 86 Months 0 Days 3 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer (Retired)

11. Industry or business

FATHER
12. Name John Sligh
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name
15. Birthplace Baltimore Md

16 (a) Informant Susanna Blinker
(b) Address 2534 E Eagan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson Bros Inc
(b) Address 1219 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

A 1945 Huntington Williams, M.D.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 12 1945; and that I last saw h[illegible] alive on May 11 19 45

Immediate cause of death: Hypertension — Duration 1 yr

Due to: Cardio Vascular Renal

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred A Bunda M. D.

Address 20 N Bethel St Date signed May 14 45

G28841 BALTIMORE CITY HEALTH DEPARTMENT G28841

CERTIFICATE OF DEATH 1372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Middle town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Remsberg
3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NONE
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Gertrude Remsberg
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 13, 1876
8. AGE: Years 68 Months 9 Days 26 If less than one day hr. min.
9. Birthplace Middletown, Frederick, Maryland (town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Henry C Remsberg
13. Birthplace Middletown Maryland

MOTHER
14. Maiden Name Mahalia Reifsnider
15. Birthplace Middletown Maryland

16 (a) Informant Vernon Remsberg
(b) Address Middletown Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Reformed
Location Middletown Md
18 (a) Funeral director Gladhill
(b) Address Middletown, Md
19 (a) MAY 14 1945 Huntington Williamsport, Md
(Must not be registered later than 5 days after death) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 1.50 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to May 9 1945.
and that I last saw h i m alive on May 9 1945.
Immediate cause of death Respiratory failure
Due to Cardiac decompensation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation April 27 1945
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Millard J Tralor Jr
Address University Hospital Date signed 5/9/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G28842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 N. Bentalou St.
(c) Hospital or institution:
16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CLARA M. B. BYE

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry H. Bye

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1872

8. AGE: Years 72 | Months 6 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Beeler
13. Birthplace Va.

MOTHER
14. Maiden Name Susan Mills
15. Birthplace Md.

16 (a) Informant Mr. Henry B. Bye
(b) Address 3053 Brighton St.

17 (a) Burial (b) Date thereof 5/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 14 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 19 , to May 12 1945 and that I last saw her alive on May 12 1945

Immediate cause of death: Cardio-vascular hypertensive disease — Duration: 10 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer C. Todd M.D.
Address 735 N. Fulton Ave Date signed 5/14/45

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G28843 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 and Wyman Park Drive
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Calvert
(c) City or town Solomons (If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward Swift

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.27, 1866

8. AGE: Years	Months	Days	If less than one day
78	4	17 18	hr. min.

9. Birthplace Northumberland Co., Va. (Town, county, and state)
10. Usual Occupation Retired M.S.
11. Industry or business

FATHER
12. Name Adniron Swift
13. Birthplace Northumberland Co., Va.

MOTHER
14. Maiden Name Mary Louise Rogers
15. Birthplace Northumberland Co., Va.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, 11, Md.

17 (a) Removal (b) Date thereof 5/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Rosemont Sec 9

18 (a) Funeral director Wilson Col Inc
(b) Address 1211 Park Ave

19 (a) MAY 14 1945 Registrar
(Date received by Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 1:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1945 to May 14 1945, and that I last saw him alive on May 14 1945

Immediate cause of death	Duration
Loclized arteriosclerosis of the coronary arteries and myocardial scarring.	Unk.
Due to Generalized arteriosclerosis	Unk.
Due to	
Other Conditions osteo arthritis	

(Include pregnancy within 3 months of death)
Date of operation none done
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.C.Archer M. D.
Address U.S.Marine Hospital Date signed 5/14/45
Baltimore, 11, Md.

G28844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28844 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 Aliceanna St
(c) Hospital or institution: 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Aliceanna St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Baranowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Emilia Baranowski
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov. 30 1898

8. AGE: Years	Months	Days	If less than one day
46	5'	15' 19	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Baranowski
13. Birthplace Poland

MOTHER
14. Maiden Name Karolina Duda
15. Birthplace Poland

16 (a) Informant Mrs Emilia Baranowski
(b) Address 1929 Aliceanna Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 16 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19. (a) MAY [illegible] 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to May 13 1945, and that I last saw him alive on May 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration
R. Hemiplegia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew L. Kwiatkowski M. D.
Address 207 E Eastern Ave Date signed

X

G28845

3-23416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G28845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Family residence
(d) Street No. 5701 East Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Havant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis Charles Havant

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Elizabeth M. Chaney

15. Birthplace Baltimore Md.

16 (a) Informant Birth Cert.

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 7 1945

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 14 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1945, at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1945 to 5/2 1945 and that I last saw h[illegible] alive on 5/1 1945

Immediate cause of death Aspiration Pneumonia — Duration

Due to

Due to

Other Conditions Fetal Atelectasis Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Stabile M. D.
Address Md. Gen'l. Hospital Date signed

2701 187

Please write plainly in ink. Information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28846 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G28846

CERTIFICATE OF DEATH

✓159

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME BARBARA LEE WITTEVEEN

If U. S. Veteran specify WAR

(a) Residence: No. 2323 MARYLAND AVE St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 8 1945

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
		4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md.

FATHER

13. NAME WILLIAM IVES

14. BIRTHPLACE (city or town) (State or country) ? North Carolina

MOTHER

15. MAIDEN NAME MARY WELSH

16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT Mary Witteveen
(Address) 2323 Maryland Ave

18. BURIAL, CREMATION, OR REMOVAL
Place [redacted] MAY 14 1945 19.

19. UNDERTAKER Commissioner of Health
(Address)

MAY 14 1945 Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 12 , 1945

22. I HEREBY CERTIFY, That I attended deceased from May 8 , 1945, to May 12 , 1945

I last saw him (her) alive on May 12 , 1945 Death is said to have occurred on the date stated above, at 4.30 m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Respiratory failure	4 hrs.

Other contributory causes of importance:

Extreme prematurity - birth wt. 2 lbs.	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Leonard Epps M. D.

(Address) Volunteers of American Hosp.

V8 8

2702 X

OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. 628847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland Ave
(c) Hospital or institution:
West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. #6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 - Kinsway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Smardo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1945

8. AGE: Years — Months — Days — If less than one day 11 hr. 30 min.

9. Birthplace West Balto. Gen. Hosp.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Ferris Smardo
13. Birthplace Hastings Penna.

MOTHER
14. Maiden Name Mary Elizabeth Lesko
15. Birthplace Portage Penna.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 MAY 14 1945 (Date rec'd by registrar) (b) Registrar

UNIVERSITY MEDICAL SCHOOL MAY 14 1945
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 4:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/10 1945 to 5/11 1945 and that I last saw h[illegible] alive on 5/10 1945

Immediate cause of death	Duration
Prematurity (2lb 4 oz)	1 da
Due to Premature separation of placenta.	1 da
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Way M.D. M. D.
Address West Balto Gen. Hosp. Date signed 5/11/45

2703

VS 150

X

G28848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

557

G28848 (over)

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 and Wyman Park Drive
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days 5mo.10
(e) Length of stay in Baltimore (yrs., mos., or days) as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4120 Audrey Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Crockett, John Alvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Mathilda Shores

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?1870

8. AGE: Years 75 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russells Island, Va.
(Town, county, and state)

10. Usual Occupation Captain, Merchant Seaman

11. Industry or business Sea-faring

FATHER
12. Name John Crockett
13. Birthplace ? Va.

MOTHER
14. Maiden Name Sarah Phillips
15. Birthplace Cape Charles, Va.

16 (a) Informant U.S.Marine Hospital Records
(b) Address Baltimore, 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1945 (month) (day) (year)
(c) Cemetery or crematory Tangier Island
Location Tangier, Md. Va.

18 (a) Funeral director Rowland H. Pruitt
(b) Address Crisfield, Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williamsville, N.Y.

MAY 14 1945

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 45 at 9:02 AM 1:02A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 19 45 to May 14 19 45 and that I last saw h alive on May 14 19 45

Immediate cause of death Bronchopneumonia — Duration 2 days
Terminal — Unknown
Due to Epidermoid carcinoma left antrum with diffusion infiltration of orbit. — Unknown
Due to — Unknown
Other Conditions Generalized arterio-sclerosis. — Unknown
(Include pregnancy within 3 months of death)

Date of operation none done
Major findings of operations:
of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.C.Archer
U.S.Marine Hospital
Address Baltimore, 11, Md. Date signed 5/14/45

G28849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1312

G28849 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 Ashland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Peter Bub Ramsey

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-20-5124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Married

6 (b) Name of husband or wife Bessie M. Ramsey
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) July - 1915

8. AGE: Years	Months	Days	If less than one day hr.	min.
29	10			

9. Birthplace Jamestown S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Ship building.

FATHER
12. Name Abraham Ramsey
13. Birthplace Jamestown, S.C.

MOTHER
14. Maiden Name Johanne Washington
15. Birthplace Jamestown, S.C.

16 (a) Informant Bessie M. Ramsey
(b) Address 1230 Ashland Ave.

17 (a) Removal (b) Date thereof May 18-45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Jamestown S.C.

18 (a) Funeral director Lottie Gross.
(b) Address 1408 Ashland Ave.

19 (a) MAY 14 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 4.10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1945, to 5/12 1945, and that I last saw him alive on 5/12 1945.

Immediate cause of death Pneumonia — Duration 10 days.

Due to

Due to

Other Conditions Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lightston Jr. M. D.
Address 2129 Druid Hill Ave Date signed 5/13/45

G28850 472714

BALTIMORE CITY HEALTH DEPARTMENT X 56 B

CERTIFICATE OF DEATH

G28850 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Franklin
(c) City or town Chambersburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 4.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ettie Stockslager.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-29-89

8. AGE: Years 56 | Months / | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Martin H. Stockslager
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hoover
15. Birthplace Md.

16 (a) Informant Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-1945 (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Chambersburg Pa.

18 (a) Funeral director H. C. Brauer
(b) Address Chambersburg Pa

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 MAY 14 1945 Huntington Pittsburgh, Pa.

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 13. 1945 at 10.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945 to May 13 1945, and that I last saw her alive on May 13 1945.

Immediate cause of death: Embolus, pulmonary — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-25-45

Major findings of operation: Myoma uteri, obesity

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.

Address Johns Hopkins Hosp. Date signed 5-14-45

X

628851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. 628851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6548 Parnell Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto., Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6548 Parnell Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Phillip Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/45 1943

8. AGE: Years 2 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Thomas Woods
13. Birthplace Charlottesville Va.

MOTHER
14. Maiden Name Bessie Ann Hochman
15. Birthplace Glascow Va.

16 (a) Informant Wm. T. Woods (father)
(b) Address 6548 Parnell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)
(c) Cemetery or crematory Glascow
Location Glascow, Va.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe Street.

19 (a) MAY 14 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945, to May 13 1945, and that I last saw h im alive on May 13 1945.

Immediate cause of death: Broncho-pneumonia — Duration: 3 days.

Due to

Due to

Other Conditions: Complicated by pleurisy — Duration: 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward N. Andrew M.D.
Address Hunting Ridge Rd & Mundell Rd 107
Date signed 5/14/45

VS 150

G28852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G28852 Registered No.

Correct the causes of death clearly and legibly. Physicians: please write the correct age as carefully important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 Sue Caenya (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford A. Gummer

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) sept. 12 1941

8. AGE: Years 3 | Months 8 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace baltimore md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name andrew gummer
13. Birthplace balto. md.

MOTHER
14. Maiden Name helen polen
15. Birthplace ohio

16 (a) Informant andrew gummer (father)
(b) Address 32 sue ave. essex md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof may 15/45 (month) (day) (year)
(c) Cemetery or crematory baltimore
Location end of east north ave.

18 (a) Funeral director Tully + Sailer
(b) Address 403 s. wolfe st.

19 MAY 14 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 19 , at 9:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diphtheria.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed May 14, 1945.

G688553 G688553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the exact age at death. Undertakers: please write the exact age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Overlea Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Overlea Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SENA FRANKS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Dr. H. Lee Franks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1893

8. AGE: Years 51 | Months 6 | Days 18 | If less than one day: hr. min.

9. Birthplace: Granite Md
(Town, county, and state)

10. Usual Occupation: Nurse
11. Industry or business

FATHER
12. Name: Walter E. Everett
13. Birthplace: Edmonston Md

MOTHER
14. Maiden Name: Louella Mason
15. Birthplace: Granite Md

16 (a) Informant: Mrs Lina E. Temple
(b) Address: Edmonston Hanford 6-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt Carmel Cemetery
Location: Edmonston Hanford 6 Md

18 (a) Funeral director: A. F. Friend & Sons
(b) Address: 1400 St Charles Pl

19 (a) MAY 14 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945, at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, traumatic
Fracture of Ribs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 13 1945 ? M.
(b) Where did injury occur? 3902 Overlea Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Probable fall in Home

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 14 1945

G28854

G28854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 24a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Taneytown R.F.D #2
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D. #2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. V. Pittinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1934

8. AGE: Years	Months	Days	If less than one day
10	7	11	hr. — min

9. Birthplace near Uniontown, Md.
(Town, County, and State)

10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Harry E. Pittinger
13. Birthplace Keysville, Md.

MOTHER
14. Maiden Name Anna Foreman
15. Birthplace Taneytown, Md.

16 (a) Informant Harry E. & Anna Pittinger
(b) Address Taneytown Md. R.F.D. #2

17 (a) Burial (b) Date thereof 5/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Piney Creek Brethren
Location Rural Taneytown, Md.

18 (a) Funeral director C. O. Russell Son
(b) Address Taneytown Md.

19 MAY 14 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13 1945 at 11:21 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1945 to 5/13 1945, and that I last saw him alive on 5/13 1945.

Immediate cause of death Respiratory Failure

Duration
over

Due to

Due to

Other Conditions Circulatory collapse.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.

Address Sydenham Hosp Date signed 5-13-45

G28855 ✓ G28855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 318 S. Smallwood St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. Mary Schalizki

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-4218

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Frank Schalizki

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 17, 1873

8. AGE: Years 71 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Hett

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine

15. Birthplace Germany

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Maryland

18 (a) Funeral director Logue & Schwan

(b) Address 2101 Frederick Avenue

19 (a) MAY 15 1945 Huntington Williams, M.D.

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1945, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945 to 5/12 1945, and that I last saw her alive on 5/12 1945.

Immediate cause of death Shock due Intestinal Obstruction — Duration

Due to ? Malignancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/10/45

Major findings of operation Acute Intestinal Obstruction

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard W. Stein M.D.

Address St. Agnes Hospital Date signed 5/12/45

VS 150

G28856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3813 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgianna M. Katernagel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Kate Henry C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1853

8. AGE: Years: 91 | Months: 8 | Days: 8 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Cline
13. Birthplace D. J.

MOTHER
14. Maiden Name Georgianna Moore.
15. Birthplace Md

16 (a) Informant Mrs Edna Schneider
(b) Address 3813 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3501 Old Frederick Rd

18 (a) Funeral director Harry A Nitske
(b) Address 414 Edmondson Ave Penthouse Baltimore, Md.

19 (a) (Date received by registrar) (b) Registration No.

MAY 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945, at 4:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1944 to May 11 1945, and that I last saw her alive on May 11 1945.

Immediate cause of death: Senility

Due to

Due to

Other Conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 720 Mod Sta Bldg Date signed 5/14/45

G-28857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94Q

Registered No. G-28857

1. PLACE OF DEATH: 2531 W. North Ave
(a) Baltimore City, Maryland
(b) Street address 2531 W North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 W. North Ave. (If rural give location)
(e) Citizen of foreign country? 2531 (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah O' Connor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1857

8. AGE: Years 87 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Daniel Roche
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Hafey
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Angland
(b) Address 2531 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3500 Rd Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 E Edmondson Ave.

19 (a) MAY 15 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 12 1945 and that I last saw h alive on 5/12 1945

Immediate cause of death: Coronary Thrombosis — Duration 12 day

Due to

Due to

Other Conditions: General Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Signed

Every item of information should be carefully supplied. Typewriter or PRINT PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28858 Dunnigan
4916 Hartford Rd

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310

G28858
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4921 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4921 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Appolonia Bellistri

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1858

8. AGE: Years	Months	Days	If less than one day
87	2	15	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Carmelo Amente
13. Birthplace Italy

MOTHER
14. Maiden Name Domenica Carpitano
15. Birthplace Italy

16 (a) Informant Mr Dominick Bellistri
(b) Address 4921 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 MAY 15 1945 (b) Huntington Williamsport, Md.
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 12 1945, at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 28 1944 to 5/12 1945, and that I last saw h e alive on 5/11 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	2 weeks
Due to Hypertension cardio vascular renal disease	
Due to	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Dunnigan M. D.
Address 31 E north ave Date signed 5/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 F

Registered No. G28859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County CARROLL
(c) City or town WESTMINSTER MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glenn Ruby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	4		hr. min.

9. Birthplace WESTMINSTER MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name GLENN W MILLER
13. Birthplace GAMBER

MOTHER
14. Maiden Name HELEN RUBY
15. Birthplace FREDRICK Co. MD.

16 (a) Informant BERTHA RUBY
(b) Address WESTMINSTE MD

17 (a) BURIAL (b) Date thereof 5-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOGOST GROVE
Location FREDRICK Co. MD.

18 (a) Funeral director J. F. REESE
(b) Address WESTMINSTER MD.

19 MAY 15 1945 Huntington Williams MD
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945, at 4:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1945, to May 17 1945, and that I last saw him alive on 5/17 1945.

Immediate cause of death	Duration
Toxemia	
due to cirrhosis of liver	3 mos
Due to Congenital Lues	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D. Clagett M. D.
Address University Hospital (Date signed 5/17/45

VS 150

G28860 Dr Gorby 5706 Hartford Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47F

Registered No. G28860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Beverly Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Beverly Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip J. Brenneis

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-0279

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1850

8. AGE: Years	Months	Days	If less than one day
64	10	8	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Josephine A Brenneis
(b) Address 3002 Beverly Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Hartford Rd

19 (a) MAY 15 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12th 1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945 to May 12 1945 and that I last saw h[illegible] alive on May 12 1945

Immediate cause of death	Duration
(a) Mediastinal Carcinoma	1 year
Due to	
Due to	
Other Conditions Glandular Affection Axillea (Include pregnancy within 3 months of death)	2 months

Date of operation None
Major findings of operation: —
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Gorby M. D.
Address 5706 Hartford Rd Date signed 5/14/45

VS 150

G28861 — BALTIMORE CITY HEALTH DEPARTMENT — G28861

CERTIFICATE OF DEATH

83a ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Evesham Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Atkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/1886

8. AGE: Years 58 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business B. C. Health Dept

FATHER
12. Name Gustav Aidt
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy J. Murray
15. Birthplace N. J.

16 (a) Informant Mrs. O'Hearn
(b) Address 402 Winston Ave

17 (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem. (Govans)
Location Liebord & Ruck

18 (a) Funeral director 5305 Harford Rd.
(b) Address

19 MAY 15 1945 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14 1945 at 7:43 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. D'Addamio M.D.
Medical Examiner.
Date signed 5/16/45

Please write the causes of death clearly and legibly. Physicians: please write the causes as especially important.

28862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

✓ G28862 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Woodbourne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Woodbourne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Rosenstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Reuben

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 20 1866

8. AGE: Years 79 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Harford Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Shonbalgue SHARPBARBER
13. Birthplace ## Md

MOTHER
14. Maiden Name Christian Cornwall
15. Birthplace ## N.Y. CORNWELL

16 (a) Informant Engine Rosenstein
(b) Address 6326 Bellona Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William Cooper & Sons
(b) Address 2219 E Fayette St

19 (a) MAY 15 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 11 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1944, to May 14 1945, and that I last saw her alive on May 14 1945.

Immediate cause of death Chr. Interstitial Nephritis
arteriosclerosis

Duration
1 yr
3 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl H Benson M.D.
M. D.
Address 5111 York Rd Date signed May 14 1945

(over) X

G28863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G28863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 James St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 James St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A Simms

3 (b) If veteran, name war 1C
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15-1863

8. AGE: Years 82 | Months 2 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Simms
13. Birthplace Va

MOTHER
14. Maiden Name Louise Mitchell
15. Birthplace Baltimore Md

16 (a) Informant Ella L Scott
(b) Address 1328 James St

17 (a) Burial (b) Date thereof 5/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Gillum & Son
(b) Address 1219 E Lombard St

19 MAY 15 1945 (b) Huntington Williams, M.D.
(Date received by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8- 1945, to 5-13-1945 and that I last saw h[illegible] alive on 5-13 1945

Immediate cause of death	Uremia	
Due to	Chronic Nephritis	
Due to		
Other Conditions	—	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Gelar M. D.
Address 6 W Lexington St Date signed 5/14/45

X

File G28864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 d

Registered No. G28864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Spaeth

3 (b) If veteran, name war: —
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Amelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1871

8. AGE: Years 74 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Spaeth
13. Birthplace Germany

MOTHER 14. Maiden Name Anna Ankenbrand
15. Birthplace Germany

16 (a) Informant Mrs Edward Spaeth
(b) Address 1808 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1317 E Pratt St

19 (a) MAY 15 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 12 ½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 29 1945 to May 14 1945 and that I last saw h[illegible] alive on May 13 1945.

	Duration
Immediate cause of death: Cerebral hemorrhage	2 mos
Due to: Arteriosclerosis	8 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer U. Todd M. D.
Address 735 N. Fulton Av Date signed 5/14/45

Beury

G28865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164D

Registered No. G28865

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 Magnolia Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James T. Beury

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Winifred F.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 21 1881

8. AGE: Years 63 | Months 5 | Days 23 | If less than one day .....hr. .....min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Coal Mine Executive

11. Industry or business

FATHER
12. Name William Beury
13. Birthplace Llewelyn Pa.

MOTHER
14. Maiden Name Susan M. Cockel
15. Birthplace Llewelyn Pa.

16 (a) Informant Mr. Eugene Kibbe
(b) Address 5616 Magnolia Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/14/45 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cemetery
Location Atlantic City N.J.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) MAY 15 1945 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 12 15 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Incised stab wound of neck; Incised wounds of wrists

Due to .....

Other Conditions Mental Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 14 1945 12 15 P.M.
(b) Where did injury occur? 5616 Magnolia Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Cut throat suicide

23. Signature Robert Lee Gentzler M.D. Medical Examiner.
Date signed May 14 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

628866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

Registered No. 628866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Belvieu AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY EDNA TAGG

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1875

8. AGE: Years 69 | Months 5 | Days | If less than one day hr. min.

9. Birthplace EASTON MD.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name REV. F.T.TAGG
13. Birthplace MD.

MOTHER
14. Maiden Name ANNIE DVER (Dever)
15. Birthplace MD.

16 (a) Informant ROBERT M. TAGG
(b) Address 24 AINTREE ROAD

17 (a) BURIAL (b) Date thereof MAY 15.45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CHESTERFIELD CEMETERY
Location CENTREVILLE MD.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 EUTAW PLACE

(Date) MAY 15 1945 (Registrar) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12. 1945 19 at 6 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to 5-12 1945
and that I last saw h alive on 5-12 1945

Immediate cause of death Right side Hemiplegia
Due to Hypertension.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hermann G. Dever M. D.
Address MEDICAL ARTS BLDG. Date signed

11 tp 12

G28867 G28867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 Carswell St
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Carswell St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Greece

3 (a) FULL NAME Peter Stomas

3 (b) If veteran, name war NO
3 (c) Social Security Account No. NO

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 5 1878
8. AGE: Years 67 Months 0 Days 7 If less than one day hr. min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business Peanuts

FATHER
12. Name Peter Stomas
13. Birthplace Greece

MOTHER
14. Maiden Name Unknown
15. Birthplace Greece

16 (a) Informant Jack Marinakis
(b) Address 2907 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Evangelismos
Location Baltimore, Md.

18 (a) Funeral director John Miller
(b) Address 2334 E. Jefferson St.

19 (a) (Date received by local registrar) MAY 15 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to May 12 1945, and that I last saw him alive on May 12 1945.

Immediate cause of death: Acute Dilatation of Heart — Duration 3 hrs
Due to: Influenza — 3 days
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T F A Stomas M D
Address 1878 Harford Rd Date signed 5-12-45

VS 150

G28868 ✓ G28868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully important.

1. PLACE OF DEATH: 4011 Walbrad Ave.
(a) Baltimore City, Maryland
(b) Street address 4011 Walbrad Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Walbrad Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Fuegel

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-5599

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Margaret Fuegel
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	21 23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired Plumber
11. Industry or business

FATHER
12. Name John Fuegel
13. Birthplace Germany

MOTHER
14. Maiden Name Auguste Seidel
15. Birthplace Germany.

16 (a) Informant Margaret Fuegel, "wife"
(b) Address 4011 Walbrad Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14/1945 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Fredk Ave, Balto. Md

18 (a) Funeral director Dill Bros.
(b) Address 3109 Frederick Ave.

19 (a) (Date rec'd by registrar) MAY 15 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1939 to 5/13 1945, and that I last saw him alive on 5/12 1945.

Immediate cause of death	Duration
Lymphatic Leucemia	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Druid Park Date signed 5/14/45

X

G28869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G28869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony L. Geppi

3 (b) If veteran, name war: no

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mabel Geppi

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1912

8. AGE: Years	Months	Days	If less than one day
33	3	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Taxi Chauffeur

11. Industry or business

FATHER
12. Name Vincent Geppi
13. Birthplace Sicily

MOTHER
14. Maiden Name Rose Geppi
15. Birthplace Sicily

16 (a) Informant Rose Geppi
(b) Address 2340 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St. Huntington Williamsport Md

19 (a) MAY 15 1945 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945, at 9:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to carbon Monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-12-45 at 9 A. M.
(b) Where did injury occur? 2104 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Gas from stove

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 13 1945

X

C28870 Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

C28870 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1440 Presstman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rowena Breckenridge
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Basil Breckenridge
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) DEC. 17, 1899
8. AGE: Years 45 46 | Months 4 | Days 25 | If less than one day ..... hr. ..... min.
9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Daniels
13. Birthplace 2. 4

MOTHER
14. Maiden Name Maria Combs.
15. Birthplace 2. 2.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15-1945 (month) (day) (year)
(c) Cemetery or crematory Baydellstown Co
Location Balto Co
18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St.
19 (a) MAY 15 1945 (Date rec'd by registrar) Registrar's No. M

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 12.35 M
21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to May 12 1945; and that I last saw h[illegible] alive on May 11 1945.

Immediate cause of death Pneumonia
Shock
Due to Staphylococcal Septicemia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 5-11-45
Major findings of operation Staphylococcal pneumonia
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address The Johns Hopkins Hosp. Date signed 5-12-45

Funeral approved: Robert Lee Graham M.D.

VS 150

G28871 BALTIMORE CITY HEALTH DEPARTMENT G28871

CERTIFICATE OF DEATH

Registered No. 1706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hours
(e) Length of stay in Baltimore (yrs., mos., or days) Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Hillcrest (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM I. HUBBARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. ~~Wd~~ M.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 18 | 1900

8. AGE: Years 44 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Salem. (Town, county, and state)

10. Usual Occupation Shucker

11. Industry or business

FATHER
12. Name Edward
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland.

16 (a) Informant Family
(b) Address 301 Hillcrest Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Dead Line

18 (a) Funeral director L. McNeely
(b) Address 130 S. Fulton Ave.

19 (a) (Date rec'd by registrar) Washington Hill Registrar

MAY 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14/45 19 9:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were: X

IMMEDIATE CAUSE OF DEATH
Shock
Due to Traumatic amputation right leg, Compound fracture left tibia & fibula
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 5/12/45 at 5:15 P.M.
(b) Where did injury occur? Curtis Creek Yards
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? Yes
(d) Means of injury Struck by truck

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 5/13/45

X

G28872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

840

G28872 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 17 hrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State — (b) County —
(c) City or town —
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Huntingdon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McEntee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/13/45

8. AGE: Years X | Months X | Days X | If less than one day 13 hr. min.

9. Birthplace Women's Hosp. (Town, county and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name John James McEntee
13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Catherine Edgar Donnelly
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs. Catherine McEntee
(b) Address 2903 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-45 (month) (day) (year)
(c) Cemetery or crematory St Joseph's Cem
Location Govans Md

18 (a) Funeral director Geo. A. Farley
(b) Address Fulton & Fayette

19 MAY 15 1945 (b) Registrar
Huntington Hollins, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 10:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1945 to May 14 1945 and that I last saw him alive on May 14 1945.

Immediate cause of death Asphyxia

	Duration
Due to Congenital Atelectasis	
Due to Meconium	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. P. O'Sullivan
Address Women's Hosp Date signed 5/14/45

X

G28873 G28873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1200

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Juanita Lovaft.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-36

8. AGE: Years 8 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation
11. Industry or business Sc Lool

FATHER
12. Name Nelt. Lovaft.
13. Birthplace Ky.

MOTHER
14. Maiden Name Ruia May Benton
15. Birthplace Ky. Records.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof May 15. (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Payne Gap Cem
Location Jenkins Ky

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAY 15 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 13 1945, at 1035 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May-13 1945, to May-13 1945, and that I last saw h. alive on May-13 1945

Immediate cause of death Septicemia — Duration

Due to Regional Ileitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/13/45

Major findings of operation: Regional Ileitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thayer M. Edwards M.D.
Address Lt. A.C. Date signed 5-15-45

X Weirath

M. D. E. 1268-9

G2887 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G28874

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 26-4 St. ..... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME John Nicholas Hofstetter

(a) Residence: No. 709 North Pt Rd St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine

6. DATE OF BIRTH (month, day, year) May 7 1866

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	-	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Gardner

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Frank Hofstetter

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Amelia Lephard

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs Annie Hofstetter

(Address) 709 North Point Rd

18. BURIAL, CREMATION, OR REMOVAL

Place Woodlawn Date May 17 1945

19. UNDERTAKER Wm. J. Armel Funeral Home

(Address) 908 Orleans St

MAY 16 1945

20. FILED ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 14, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 10, 1945 to May 14, 1945

I last saw him alive on May 14, 1945. Death is said to have occurred on the date stated above, at 9P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	5/14/45

Other contributory causes of importance:

Arterio Sclerotic Cardio-Vascular Disease	
Pleurisy with Effusion	1 wk

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) G. M. Baumgardner M. D.

(Address) Balto Md

G28875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28875 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 435 N. Lakewood Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lambert Eichner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife (Maiden): Margaret Eichner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/1886

8. AGE: Years 59 | Months 2 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name George Eichner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lisette Eichner
15. Birthplace Baltimore

16 (a) Informant Patient
(b) Address 435 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

19 (a) MAY 15 (Date rec'd by registrar) (b) Huntington Will Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 13 1945, and that I last saw h/im alive on May 13, 1945.

Immediate cause of death: Coronary occlusion — Duration:
Due to: Arteriosclerotic heart disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B. Lewis Jr. M. D.
Address St Church Home & Hosp. Date signed 5-13-45

G28876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. G28876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Wilkens Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara A. Steinwedel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ~~xx~~ William A. Steinwedel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1889

8. AGE: Years 56 | Months 1 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sales Lady

11. Industry or business Hochschild-Kohn Co.

FATHER
12. Name James M. Graham
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Proctor
15. Birthplace Fredericksburg, Va.

16 (a) Informant Dr. Wm. A. Steinwedel
(b) Address 2001 Wilkens Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May (month) (day), 1945 (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

MAY 15 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1945, at 3.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1945 to 5/14 1945 and that I last saw h... alive on 5/14 1945.

Immediate cause of death: Coronary occlusion — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller, M. D.
Address 2030 Wilkens ave Date signed 5/14/45

VS 150

G28877 SWINGLER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31 2

Registered No. G28877

Every item of information should be carefully supplied. The undertaker should write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 White Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Bald. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Swingler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Andrew Swingler

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) July 14, 1876

8. AGE: Years 68 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Bald Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John Alberts

13. Birthplace Bald, Md

MOTHER 14. Maiden Name Marg. Schanal

15. Birthplace Bald Md.

16 (a) Informant Mr Andrew Swingler

(b) Address 3502 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 45 (month) (day) (year)

(c) Cemetery or crematory Pikewood

Location Taylor Ave.

18 (a) Funeral director L. Hecmann & Son

(b) Address 32 S. Broadway.

19 MAY 15 1945 (Date rec'd by registrar) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 45 19 , at 8:1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 12. 45 19 to May 12. 45; and that I last saw h.e alive on May 12. 45.

Immediate cause of death Hypertensive Cerebral Vascular Disease

Due to Chronic Interstitial Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Insley M. D.

Address 2536 E Bald Date signed 5/14/45

VS 150

For S. H. Davis, By Howard J. Insley, M. D.

C-28878 A-92543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C-28878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 149 Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Roseanna Coles~~ or Closanna Coles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. ~~Single~~ Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7- ~~last~~ 1912

8. AGE: Years (24) 33 Months 1 Days 7 If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William ~~Coles~~ Felder
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Bronson
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave/

17 (a) Removal (b) Date thereof 5 17 45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Manning
Location S. C.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAY 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14- 1945, at 5.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9- 1945, to 5-14 1945 and that I last saw her alive on 5-14- 1945

Immediate cause of death Cardiac Failure

Due to Hypertensive Arteriosclerotic Heart Disease

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration: ,

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 5-14-45

vs

FORM 3 WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly filled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28879 93D

Registered No. G28879

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Whatcoat Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1126 Whatcoat Street (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY BURTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Sallie Cook
(b) Address Patapsco Park-Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah T. Brantley
(b) Address 408 W Montgomery St

19 (a) MAY 15 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/45 19..., at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection of Injuries thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner
Date signed 5/7/45

VS 151

G28880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1570 C

G28880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address... Lombard & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 North Poppleton (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Hooper SR

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 119-09-7077

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 3/3/1894

8. AGE: Years 51 | Months 3 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Porter

11. Industry or business

FATHER
12. Name: Wm. B. Hooper
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden Name: Pamela Gittings
15. Birthplace: Baltimore, Md.

16 (a) Informant: Noble Bethel (Sister)
(b) Address: 729 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Natl. Cem.
Location: Balto., Md.

18 (a) Funeral director: Chas. Glover
(b) Address: 542 N. Carrollton Ave.

19 (a) MAY 15 1945 (Date rec'd by registrar) (b) Huntington Mortuary, Inc.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12/45 19... at ... M

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Shock

Due to: Crushed chest multiple fractures

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/12/45 at 2:30 P. M. 17/3
(b) Where did injury occur? 728 West Franklin St.
(c) Did injury occur at home, on farm, industrial place, in public place? On street While at work? ?
(d) Means of injury: Struck by auto

23. Signature: John L. Davis M.D. (Medical Examiner)
Date signed 5/13/45

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G28881 — BALTIMORE CITY HEALTH DEPARTMENT — 93D — G28881

CERTIFICATE OF DEATH

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write legibly important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 Denver Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Denver (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. (Snyder) Schneider

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Lucy Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. George Snyder (Son)
(b) Address 616 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 15 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14/45 19 , at 5:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 5/16/45

VS 151

G28882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28882 Registered No.

Every item of information should be carefully supplied and the entire certificate filled in. Please write plainly, with UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5408 Purlington Way. (If rural give location)
(e) Citizen of foreign country? Mo. (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Imogene Neff

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles C Neff.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1884

8. AGE: Years	Months	Days, if less than one day	hr.	min.
60	7	16		

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name George W Dell.
13. Birthplace Pa.

MOTHER
14. Maiden Name Clara Dundore
15. Birthplace Pa.

16 (a) Informant Mrs. J. E. Adkins, Jr.
(b) Address 5408 Purlington Way Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory -
Location Williamsport, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar Hunting Williamsport Union Memorial Hosp

VS 150 MAY 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1945, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1945, to 5-14 1945 and that I last saw h er alive on 5-14 1945.

Immediate cause of death	Duration
C-R failure	
Due to Intracranial Hemorrhage	
Due to Hypertensive C-V disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Brigitte Nelson M. D.
Date signed 5-14-45

G 28883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G 28883

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Estell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: child
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1945

8. AGE: Years | Months | Days | If less than one day: 1½ Hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER — 12. Name Laguire C. Estell
13. Birthplace Green Co., Pa

MOTHER — 14. Maiden Name Elizabeth L. Loot
15. Birthplace Fayette Co., Pa

16 (a) Informant Mrs. L. E. Estell
(b) Address 1119 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Harford Rd at Brooklyn

18 (a) Funeral director Elmer W. Conkling
(b) Address 92 E. Eager St.

19 MAY 15 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1945 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to May 15 1945 and that I last saw her alive on May 15 1945.

Immediate cause of death	Duration
Congenital Heart Disease	
Acute Failure just after birth	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2473 E. Monument St Date signed 5/15/45

VS 180

G28884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G28884

Every item of information should be carefully supplied. Records WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Cedarcroft Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Cedarcroft Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Ida Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1883

8. AGE: Years	Months	Days	If less than one day
61	9 8	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business —

FATHER
12. Name Gustav Bornschein
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Feldman
15. Birthplace Balto. Md.

16 (a) Informant John A. Wagner
(b) Address 406 Cedarcroft Rd

17 (a) Burial (b) Date thereof 5-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3800 Frederick Rd

18 (a) Funeral director Harry A. Wittke
(b) Address 1016 Edmondson Ave.

19 (a) [illegible] (Date) (Funeral) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1940 to 5-14 1945
and that I last saw h alive on 5-10 1945

Immediate cause of death	Duration
Uremia	5 Months
Due to Arteriosclerotic Kidney	7
Due to	
Other Conditions Diabetes	4 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Nelson Carey M. D.
Address 1014 St Paul St Date signed 5-16-45

VS 150

131a

G28885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G28885 Registered No.

FILL OUT COMPLETELY. Every item of information should be carefully supplied. Use black ink. PRINT PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. If exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Friendship Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Friendship Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARETE GESCHWENDT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Karl Geschwendt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 1, 1863

8. AGE: Years 81 | Months 10 | Days 12 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Karl Lettermann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Fredericka Otten
15. Birthplace: Germany

16 (a) Informant: Paul Geschwendt
(b) Address: 1526 Friendship Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-16-45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

1945 (Date rec'd by Registrar) (b) Clinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945, at 7.30 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr- 1935, to May 13 1945, and that I last saw h[illegible] alive on May 12 1945

Immediate cause of death	Duration
cerebral Thrombosis	10 min.
Due to arteriosclerosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert K. Mortimer Jr. M.D.
Address 2706 St Paul Date signed 5/15/45

VS 150

G28886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G28886 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3417 Leverton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 Leverton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. Horner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry Horner
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) July 24 1916.

8. AGE: Years	Months	Days	If less than one day
28 29	9	18	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William Poyner
13. Birthplace ?

MOTHER
14. Maiden Name Millie Smith
15. Birthplace Balto, Md.

16 (a) Informant Henry Horner
(b) Address 3417 Leverton Ave.

17 (a) Burial (b) Date thereof May 16. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Reisterstown Highway

18 (a) Funeral director Wendell D. Hagel
(b) Address 312 S. Highland Ave.

19 (a) MAY 15 1945 Huntington Hollow, Md.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation of Heart

Due to

Other Conditions Fatty degeneration of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gutheim M.D.
Medical Examiner.
Date signed May 13 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G28887 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1460 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 E Eddy Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Toissaint

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Anna -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 1874

8. AGE: Years	Months	Days	If less than one day
71	4		hr. min.

9. Birthplace Alsace-Lorraine - France (Town, county, and state)

10. Usual Occupation Dispensary

11. Industry or business St. Josephs

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Beatrice Dorsey
(b) Address 549 Bayside drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director L. J. Rusk
(b) Address 5305 Harford Rd

19 (a) (Date received) MAY 15 1945 (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1945 to 5-13 1945 and that I last saw him alive on 5-12 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Hypertensive Cardio-Vascular disease	
Due to	
Other Conditions Acute alcoholism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
St Joseph's Hospital Date signed 5-13-45

VS 150

G:28888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G:28888

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Harford Road (Or other descriptive location)
(e) Citizen of foreign country? Colvert St. (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Ada~~ Aria Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age 18 yrs

7. Birth date of deceased (mo., day, yr.) Aug 26-

8. AGE: Years 80 | Months 8 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ✓
13. Birthplace

MOTHER
14. Maiden Name ✓
15. Birthplace

16 (a) Informant Mrs. Aria Wolfe
(b) Address N. York State

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-45 (month) (day) (year)
(c) Cemetery or crematory Moreland PK
Location Balto

18 (a) Funeral director L. J. Ruck
(b) Address 5300 Harford Rd.

19 (a) MAY 15 1945 (Date received by registrar) (b) Arlington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14/45 19... at 5:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John A. Wurt Medical Examiner. M.D.
Date signed 5/14/45

Type or use ink. Spell out all words. Do not abbreviate. Physicians: please write the causes of death clearly and legibly.

28889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G28889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1728 Bolton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Fox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie H Fox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25-1861

8. AGE: Years	Months	Days	If less than one day
83	5-	19	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Samuel Fox
13. Birthplace Balto Md

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Mrs Sadie H Fox
(b) Address 1724 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md

18 (a) Funeral director David Sondheim & Son
(b) Address 1902 Eutaw Pl.

MAY 15 1945 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to May 14 1945, and that I last saw h alive on 5-14-1945.

Immediate cause of death	Duration
Cerebral embolism	
Due to Chr nephritis	
Due to Heart Block	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Bernard Cohen M. D.
Address Maryland Date signed

X

Dr Alessi G28890
6217 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28890 Registered No.

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6235 Bellona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Brooklyn - N.Y. (If outside city or town limits, write RURAL and give town)
(d) Street No. 99 Huron Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Catherine De Sarzy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James Joseph De Sarzy 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8-1872

8. AGE: Years	Months	Days	If less than one day
72	6	7	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary DeSarzy
(b) Address Brooklyn - New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 45 (month) (day), (year)
(c) Cemetery or crematory Calvary Cemetery
Location Brooklyn - New York

18 (a) Funeral director John J. Miller Jr.
(b) Address 2455 E. Oliver St.

19 (a) May 15 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1945 to May 15 1945 that I last saw h alive on May 15 1945.

	Duration
Immediate cause of death Gangrene left leg	# days
Due to Fracture left leg	5 wks
Due to Arteriosclerotic C-V-R disease.	5 yrs.
Other Conditions Chr. arthritis	25 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 4-7-45 at P.M.
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? —
(e) Means of injury Fell from bed.

23. Signature 6217 Harford Road M. D.
Address Date signed

S. th Alessi X

G28891 BALTIMORE CITY HEALTH DEPARTMENT G28891
CERTIFICATE OF DEATH 1930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2924 Ellicott Driveway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Ellicott Driveway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella E. Howard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John R. Howard
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 16th 1860

8. AGE: Years 64 65 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Geo. W. Fresh
13. Birthplace Germany

MOTHER 14. Maiden Name Lucy Keegan
15. Birthplace Md

16 (a) Informant Lillian H. Maund
(b) Address 2924 Ellicott Driveway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. B. Hopkins & Son
(b) 1400 Eutaw Place

15 1945
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 1.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to May 12 1945, and that I last saw her alive on May 12 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 hrs
Due to: Arterial Hypertension	4 years
Due to:	
Other Conditions: Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Harrell Pierce M. D.
Address 312 Med. Arts Bldg. Date signed 5-14-45

G28892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G28892 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 W Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 W Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette D. Naccarato

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-14-5499

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm A. Naccarato

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 2 1908

8. AGE: Years 36 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Pennsylvania (town, county, and state)

10. Usual Occupation

11. Industry or business Raleigh Clothing Mfg Co

FATHER 12. Name Alexander Angis
13. Birthplace Italy

MOTHER 14. Maiden Name Elizabeth Simonetis
15. Birthplace Lithuania

16 (a) Informant Wm F Naccarato
(b) Address 328 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md

18 (a) Funeral director H. C. Fairfield Son
(b) Address 700 Eutaw Place

19 (a) May 5 1945 (b) (Local Registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 at 11:46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Mar 1945 to 11 May 1945; that I last saw he alive on 11 May 1945

Immediate cause of death	Duration
Adeno Carcinoma of recto-sigmoid with metastasis to peritoneum	
Due to liver and uterus.	
Due to	
Other Conditions (Include pregnancy within three months of death)	

Date of operation 16 Aug 1944
Major findings of operation: as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew J Parker Capt USC M.D.
Address Gen. Disp. Post Bldg Date signed May 7/45

VS 150

X

G28893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G28893 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2030 W. North Ave.
(c) Hospital or institution:

15th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE DOBSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	White	Married

6 (b) Name of husband or wife J. Thomas Dobson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1879

8. AGE: Years	Months	Days	If less than one day:
66	2	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Keith
13. Birthplace Balto.

MOTHER
14. Maiden Name Susan Stuart
15. Birthplace Balto.

16 (a) Informant Mr. J. Thomas Dobson
(b) Address 2030 W. North Ave.

17 (a) Burial (b) Date thereof 5/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAY 15 1945 (Signature) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1945, at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/45 19 to 5/14/45 19; and that I last saw h[illegible] alive on 5/14/45.

Immediate cause of death Surgical (Coma) Duration 4 hrs
Due to Thrombosis of basilar artery
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Hamer, M.D.
Address 4 W. Mt. Vernon Pl. Date signed 5/15/45

G28894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G28894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 Wallbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 Wallbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne B. Topper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1877

8. AGE: Years 68 Months 2 Days 25 If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic wife

11. Industry or business

FATHER 12. Name Joseph Schandelmeyer

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Yost

15. Birthplace Balto. Md.

16 (a) Informant Mrs. William Zaplatich

(b) Address 2133 Wallbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Fahey Sons

(b) Address 1827 N. North Ave.

19 (a) (Date received by Registrar) (b) Registrar

MAY 15 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14/1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 1943, to MAY 14 1945, and that I last saw her alive on MAY 7 1945.

Immediate cause of death CARCINOMA, SQUAMOUS CELL FACE AND NOSE — Duration 2½ YEARS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1918.

Major findings of operation: CARCINOMA

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. W. Hoffman, M.D.

Address 8 East Read St Date signed 5/17/45

M. D.

X

28895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G28895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymon
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2348 N. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3.(a) FULL NAME Ella H Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Texas Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Frank McNeil Devitt
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Ireland

16 (a) Informant Miss Mary Burke
(b) Address 1348 Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-1945 (month) (day) (year)
(c) Cemetery or crematory St Joseph Cemetery
Location Texas Md

18 (a) Funeral director Mary M Wardefield
(b) Address 201 E. 22nd St

MAY 16 1945

(b) Huntington Williamsport, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945 to 5/14 1945, and that I last saw her alive on 5/14 1945.

Immediate cause of death	Duration
Generalized infection, abscess left hip, Pulmonary tuberculosis and pyuria, debilitation	
Due to Pneumonia, bilateral lobar	
Diabetis mellitus, Abscess	
Due to Right adrenal gland and kidney, Congestive	
Other Conditions Heart failure Arteria sclerotic cardio vascular	

(Include pregnancy within 3 months of death)

Date of operation disease

Major findings of operation:

of autopsy: Pleural effusion, Pericardial effusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Baldwin M.D.

Address West Baltimore General Hosp. Date signed 5-14-45

X

G28896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135B

Registered No. G28896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Dennison St (If rural give location)
(e) Citizen of foreign country? DENNISON (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph T Donovan

3 (b) If veteran, name war —
3 (c) Social Security Account No. none
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 75 Months Days If less than one day hr. min.
9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Alexander N Sutton
(b) Address 64 Talbot Blvd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md
18 (a) Funeral director Fulton Funeral Home
(b) Address 624 E Fayette St
19 MAY 16 1945 (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945 at 12 M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1933 to Aug 16 1945, and that I last saw h[illegible] alive on Aug 15 1945.

Immediate cause of death	Duration
Infection due to multiple bedsores	
Due to Long weight	
Due to Loss of Sphincter Control	
Other Conditions Hypostatic pneumonia,	
Recent attack of Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury
23. Signature John A Luetcher M. D.
Address 12 Draper St Date signed May 16/45

VS 150

G28897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28897
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 Brighton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Joseph Airey

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-8682

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1882

8. AGE: Years	Months	Days	If less than one day
63	1	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry Blaw Knox Co. - Pittsburgh, Pa.

FATHER
12. Name Charles Airey
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Margaret E. Airey
(b) Address 3105 Brighton St.

17 (a) Burial (b) Date thereof 5/17/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAY 19 1945 (b) Huntington Williams M.D.
Date received by Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1945, at 3:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1945 to May 15 1945 and that I last saw h~~im~~er alive on May 12 1945

Immediate cause of death	Duration
Cardiac Vascular failure	3 days
Due to Arteriosclerosis.	four years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Burman Ford M. D.
Address 2200 Garrison Blvd Date signed 5/15/45

VS 150

G28898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G28898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Port ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) **FULL NAME** William H. Heiger

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-07-3722

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife ? Deand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1877

8. AGE: Years	Months	Days	If less than one day
67	7	14	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business ?

FATHER 12. Name Joseph Heiger
13. Birthplace Germany

MOTHER 14. Maiden Name Louise Pessinger
15. Birthplace Germany

16 (a) Informant Mrs. Thomas Cassady (sister)
(b) Address 3135 Ravenwood R

17 (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location North & Milton Aves

18 (a) Funeral director Harry M. Blight Jr
(b) Address 4914 Belair Road

19 (a) (b)
(Signature and title) Registrar

MAY 16 1945
VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 14 1945, and that I last saw h[illegible] alive on May 14 1945

Immediate cause of death	Duration
Tuberculosis, pulmonary	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion L. Davis M. D.
Address Church Home Date signed 5-14-45

X

G28899 ✓ G28899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida L. Holton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank Penn
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Dorsey
15. Birthplace Maryland

16 (a) Informant Mrs. Mary G Ferguson
(b) Address 2129 Penn Ave Balto Md

17 (a) Burial (b) Date thereof May 19-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olive Cemetery
Location New Windsor Finksburg Road

18 (a) Funeral director D. D. Hartley & Son
(b) Address Kenwood Bridge & West Hunter Md

19 (a) (b) Huntington W. Va.
(Date rec'd by local reg.)

MAY 18 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 4 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945, to May 16 1945, and that I last saw h[er] alive on May 16 1945.

Immediate cause of death	Duration
Due to Intestinal Obstruc.	
Due to Ca of Sigmoid	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation May 13, 1945

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. P. Tompkins M.D.

Address Mercy Hosp. Date signed 5/16/45

G28960 Le Adams

BALTIMORE CITY HEALTH DEPARTMENT ✓ G28900

CERTIFICATE OF DEATH 46 F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Mace St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Mace st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife Frank

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-14-1903

8. AGE: Years 42 | Months 2 | Days — | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Henry Hutchinson
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Frances Johnson Smith
(b) Address 569½ Orchard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 18 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Williams & Jackson
(b) Address 946 Penna Ave

19 MAY 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5, 1945 to May 14 1945, and that I last saw h-r alive on May 13 1945.

Immediate cause of death Cancer of liver

Duration 1 yr ?

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Anne Adams, M. D.
Address 3126 23rd N Date signed 5-16-45

X

G28901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G28901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: 306 E. Lafayette Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George C. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7866

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	m.

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1895

8. AGE: Years	Months	Days	If less than one day
50	4	13	hr. min.

9. Birthplace Queen Anne Co.
(Town, county, and state)
10. Usual Occupation R.R.
11. Industry or business

FATHER
12. Name George B. Cook.
13. Birthplace Queen Anne Co.

MOTHER
14. Maiden Name Seney
15. Birthplace

16 (a) Informant Emma Cook
(b) Address 306 E. Lafayette Ave

17 (a) removal (b) Date thereof May 16 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Church Hill Cem.
Location Eastern Shore Md.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Fremmont Ave

19 MAY 16 1945 (b) Huntington Williams
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 45 to May 14 1945.
and that I last saw h[illegible] alive on May 14 1945

Immediate cause of death Coronary Occlusion — Duration

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Jack J. Singer
Address 506 E North Ave Date signed 5-16-45 M. D.

G28902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G28902

VO #16113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 3 - 4
(e) Length of stay in Baltimore (yrs., mos., or days) since birth

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homeless (If rural give location)
(e) Citizen of foreign country? .....(Yes or No) If yes, name country.....

3 (a) FULL NAME George Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16, 1867

8. AGE: Years	Months	Days	If less than one day
77	11	27	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John T. Simpson
13. Birthplace Maryland

MOTHER
14. Maiden Name Lizzie Dusick or Busick
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory Balto. 5-17-1945
Location E. North Ave Ext

18 (a) Funeral director Leo G. Crook
(b) Address 701-03 N. Patt. Park Ave.

MAY 16 1945 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9, 1927, to May 13, 1945, and that I last saw him alive on May 13, 1945.

	Duration
Immediate cause of death Cardiac decompensation	3 wks.
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions Decubitus ulcers. (Include pregnancy within 3 months of death)	2 wks

Date of operation 2-25-41
Major findings of operation: Arterio Sclerotic gangrene lower extremity
of autopsy: Thrombosis femoral artery

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....
23. Signature Hauck E. Belton, M.D.
Address Balt. City Hosp. Date signed 5/17/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G28903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28903 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Harview Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Tahm.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Ernest Tahm.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26 1862.

8. AGE: Years 83 | Months 0 | Days 22. | If less than one day hr. min. 19

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: None.

11. Industry or business

FATHER
12. Name: John Steinrechen
13. Birthplace: Md.

MOTHER
14. Maiden Name:
15. Birthplace

16 (a) Informant: Mrs. Charles. Kreopach.
(b) Address 2818. Harview Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director: Ellrich Funeral Home
(b) Address 200 S Allegany Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 17 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 1945 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1945 to 5-15 1945.
and that I last saw h[illegible] alive on 5-15 1945.

Immediate cause of death	Duration
C-R failure	
Due to Arteriosclerotic heart disease	
Due to generalized arteriosclerosis	
Other Conditions Epilepsia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John U. Morris, M.D.
Address Md. Date signed 5-15-45

X

5217

G28904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G28904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Elm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Elm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar H Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of ~~husband~~ or wife Mollie G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11 1880

8. AGE: Years 64 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Pen R.R.

FATHER
12. Name Albert Brown
13. Birthplace unknown

MOTHER
14. Maiden Name Anna Fitzgerald
15. Birthplace unknown

16 (a) Informant Nellie Starr
(b) Address 3308 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 17 45 (month) (day) (year)
(c) Cemetery or crematory Mountain Christian Cemetery
Location Harford Co.

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36th

19 (a) (Date received by Registrar) MAY 16 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1-45 to 5-13 1945 and that I last saw h/her alive on 5-13 1945

Immediate cause of death Cerebral Hemorrhage. — Duration 8 hrs.

Due to Hypertensive Cardio vascular disease — 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify exact place) While at work?
(e) Means of injury

23. Signature [illegible] Tobacco.
Address 5217 York Rd Date signed 5/15/45

Huntington Williams, M.D.

Entries must be written in ink, with typewriter, or indelible pencil. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G28905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G28905

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Bruns St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Julius

3 (b) If veteran, name war: War ?

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Day Laborer

11. Industry or business

FATHER
12. Name Henry Julius
13. Birthplace Ga.

MOTHER
14. Maiden Name Annie —
15. Birthplace Va.

16 (a) Informant James Julius
(b) Address 512 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location

18 (a) Funeral director James Astarys
(b) Address 142 W. Hill St

19 (a) MAY 19 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14 19 45, at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulinski M.D. Medical Examiner.
Date signed 5/17/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 Pontiac Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits write RURAL and give town)
(d) Street No. 817 Pontiac Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Lang. (ZANG)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-14-1740

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1874

8. AGE: Years	Months	Days	If less than one day
71	1	1	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Charles Lang
13. Birthplace Germany

MOTHER 14. Maiden Name Anna Bauer
15. Birthplace Germany

16 (a) Informant Mrs Frances L. Null
(b) Address 817 Pontiac Ave.

17 (a) Burial (b) Date thereof 5-17-45
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross.
Location Md.

18 (a) Funeral director Thomas J. Shuman
(b) Address 1476 Light St.

19 (a) MAY 16 1945 Huntington Williams M.D.
Date received by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14 1945, to 5/15 1945, and that I last saw h alive on 5/14 1945

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.

Address 203 Betsy Ave Date signed

AB- 90561 G28907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. G28907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6mos. 7days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann H. Beetley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17- 1857

8. AGE: Years	Months	Days	If less than one day
87	11 10	7 27	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Beetley
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Norris (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Pat[illegible]
Location Edmondson Ave
Baltimore Co.

18 (a) Funeral director [illegible]
(b) Address 24[illegible] E. Oliver St

19 (a) [illegible] Huntington Williams, M.D. Registrar
Date received MAY 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 3.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1944, to 5-14 1945, and that I last saw h er alive on 5-14 1945.

Immediate cause of death: Arteriosclerotic cardiovascular renal disease — Duration: years

Due to: Senility, emphysema — years

Due to:

Other Conditions: fractured left femur & cachexia — 6 mos.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Arteriosclerotic
for
of autopsy Arteriosclerotic nephritis, etc
(Above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/4
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 11-2-44 at M
(c) Where did injury occur? home 3124 E. Hoffman
(City or town) (County)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work?
(Specify type of place)
(e) Means of injury fell down steps

23. Signature R. H. Cunningham M. D.
Address Balto City Hosp Date signed 5-15-45

TO BE APPROVED BY MEDICAL EXAMINER
DR. JOHN R. DAVIS - PER: Robert L. Gentzler X 5/16/45

G28908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G28908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2464 Longwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Leibowitz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Next Relative
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-45 (month) (day) (year)
(c) Cemetery or crematory Jewish Friendship
Location Phila Pa
18 (a) Funeral director Jack Louis Lee
(b) Address 1439 E. Balto St
19 (a) MAY 16 1945 (Date received by registrar) Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 1945 at 5:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1945 to 5-15 1945 and that I last saw her alive on 5-12 1945

Immediate cause of death Cardio-respiratory arrest. — Duration

Due to Cerebral haemorrhage

Due to Cerebral sclerosis & arteriosclerosis

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Tucker M.D. M. D.
Address Sinai Hosp. Date signed 5-15-45

830

G28909 ✓ G28909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 A East University Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 A East University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERTHA GILES BYRD

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Edgar Byrd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/1885

8. AGE: Years 60 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward M. Giles
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma D Owings
15. Birthplace Md.

16 (a) Informant Mr. William E. Byrd
(b) Address 300 A East University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/ /45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 16 1945 (Date rec'd) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 12, 1945, at 11:15M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/44 19 , to 5/12/45 19 , and that I last saw her alive on 5/11/45 19 .

	Duration
Immediate cause of death: Generalized Carcinomatosis	1 yr
Due to: Carcinoma Ovary-Primary	18 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Fenwick W Hluck M. D.
Address 76 Park ave Date signed 5/14/45

VS 150

G28910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G28910 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in years, months, days. If less than one day, write hours or minutes. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 Ivy Ave (If rural give location)
(e) Citizen of foreign country? N. (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Owens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-92

8. AGE: Years 53 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation School teacher

11. Industry or business

FATHER
12. Name Sam Warren
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie ?
15. Birthplace Md.

16 (a) Informant Stewart L. Owens
(b) Address 2332 Ivy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Meth. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1681 Druid Hill Ave.

19 (a) (Date rec'd by registrar) MAY 16 1945 (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 45 at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1944 to May 14 1945 and that I last saw her alive on May 14 1945

Immediate cause of death: azatemia — Duration

Due to azidosis

Due to pelvic peritonitis

Other Conditions Carcinoma ovary

(Include pregnancy within 3 months of death)

Date of operation 5/3/45

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Felix Reelidge M.D.
Address Johns Hopkins Hosp Signed 5/14/45

X

G28911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G28911 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 Flint St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burkett Lee Pike, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Annabell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 1905

8. AGE: Years	Months	Days	If less than one day
39	6	5	hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Arundel Sand & Gravel Co

FATHER 12. Name Burkett Lee Pike

13. Birthplace D. C.

MOTHER 14. Maiden Name ?

15. Birthplace Georgia

16 (a) Informant Joseph M. Pike

(b) Address 1033 Forrest St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-45 (month) (day) (year)

(c) Cemetery or crematory Valley Memorial

Location Belair Rd.

18 (a) Funeral director Elmer H. Corbin & Son

(b) Address 924 E. Eager St.

MAY 16 1945 (Date rec'd by registrar) Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 15th 1945 ? M. 25/6
(b) Where did injury occur? Harbor - Near Fairfield Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ? yes
(d) Means of injury Found Drowned

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 15 1945

G28912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G28912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Springfield Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1873

8. AGE: Years	Months	Days	If less than one day
71	11	10	hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name George Eshman.

13. Birthplace Germany.

MOTHER 14. Maiden Name ?

15. Birthplace Germany

16 (a) Informant Mrs. Robert Schwartz

(b) Address 611 Springfield Ave City

17 (a) Burial (b) Date thereof 5/19/45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Mary's Cem.

Location Baltimore Ohio

18 (a) Funeral director John A. Hoon

(b) Address 426 Greenmount Ave.

19 (a) MAY 16 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 19 45 at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 19 45 to 5-15 19 45. and that I last saw h. alive on 5-15 19 45.

Immediate cause of death C-R failure — Duration

Due to Cerebral Hem. —

Due to Arteriosclerotic C-V disease —

Other Conditions Hypertension Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III M.D.

Address Union Memorial Hospital Date signed 5/15/45

93D.

G28913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/42D

Registered No. G28913

G28913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynard & Dukeland Sts.
(c) Hospital or institution West Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 W North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Mrs Josephine Bond. 24333

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife Walter Bond
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 7 1919

8. AGE: Years	Months	Days	If less than one day
26		9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Charles S. Cowan
13. Birthplace Md.

MOTHER
14. Maiden Name Lillian V. Sullivan
15. Birthplace Md.

16 (a) Informant Chas. S. Cowan
(b) Address Reisterstown Md.

17 (a) Burial (b) Date thereof May 18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Finkelstein
Location Carroll Co

18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown Md.

19 (a) Date received by registrar MAY 16 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1945 at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1945, to 5/15 1945.
and that I last saw h.e.r alive on 5/15 1945.

Immediate cause of death	Duration
Pulmonary edema and Embolism	
Due to (1) Post partum Hemorrhage	
(2) Amniotic Fluid	
Due to Meconium Embolism meconium	
(3) Rapid Labor	over

Other Conditions Contracted outlet - difficult delivery.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Acute Yellow Atrophy Multiple Hemorrhages of autopsy Pulmonary Edema etc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Young M.D.
M. D.
Address West Balto Gen Hosp Date signed 5/15

G28914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G28914 Registered No.

Please write plainly and make no abbreviations. Date of death and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Russell Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Russell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Dillehay

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1873

8. AGE: Years	Months	Days	If less than one day
71 72	6	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Jones
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ella Harris
15. Birthplace Baltimore Md

16 (a) Informant Alexander Rogers
(b) Address 1112 Russell Street

17 (a) Burial (b) Date thereof May 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 1086 Montgomery Street

19 1945 (Date rec'd by registrar) Huntington Williams, M Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13- 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3- 1945, to 5-13- 1945, and that I last saw h alive on 5-12- 1945.

Immediate cause of death — Duration

Due to Nephritis Senility

Due to —

Other Conditions Old Age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C Carper M. D.
Address 1016 S. Sharp St Date signed 5-15-45

G28915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 G28915 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 George Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alonzo Hall

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jessie Hall
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Jones
15. Birthplace North Carolina

16 (a) Informant Jessie Hall
(b) Address 156 W Hamburg Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah A Brown Son
(b) Address 1419 W Montgomery Street

19 (a) MAY 16 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14- 1945, at 8 35 A. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 5-14-45

VS 151

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G28916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

G28916 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Ave
(c) Hospital or institution: Baltimore 29. Md. Jewish Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie E. Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1875

8. AGE: Years 69 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Cockeysville Maryland (Town, county, and state)

10. Usual Occupation Retired Teacher

11. Industry or business

FATHER
12. Name John H Gardner
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Tucker
15. Birthplace Virginia

16 (a) Informant Jewish Memorial Hosp
(b) Address 1000 Eaton Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 16-1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road

19 (a) (b)
(Person acting as undertaker)

MAY 16 1945

Huntington Williams Mfg Co

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1945, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944, to 5/15 1945, and that I last saw h[illegible] alive on 5/15 1945

Immediate cause of death Heart failure — Duration

Due to Chronic Compensated Degeneration

Due to

Other Conditions Severe Arthritis Deformans (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address 6 Eyres Road Date signed 5/16/45

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

G28917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28917 Registered No.

Every item of information should be carefully written. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 850 Carroll St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 Carroll St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary B. Reilly

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife late Geo B. —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 23, 1867

8. AGE: Years 78 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name John Lonigan
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Toohey
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Frances
(b) Address 1235 Glyndon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Hoodland Ave.

18 (a) Funeral director John H Coward & Son
(b) Address 901-03 W Fayette St

MAY 16 1945 (a) (Date received by registrar) (b) Huntington Williams M.D. Commissioner of Health

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1945, to 5-15-1945 and that I last saw h— alive on 5-15 1945

Immediate cause of death Acute Heart Failure — Duration —
Due to Chronic myocarditis —
Due to —
Other Conditions Arteriosclerosis —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Louis H Loomis M. D.
Address 876 Wilkens Ave Date signed —

X Glass 5/16/45

G28918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G28918 Registered No.

Please answer questions 1 to 23 in full. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Fayette Sts
(c) Hospital or institution: D.O.A. Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella F Haven

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John F Haven

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 14, 1888

8. AGE: Years	Months	Days	If less than one day
57	3	1	hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name William T. Hurst
13. Birthplace Georgia

MOTHER
14. Maiden Name Artodia Simmons
15. Birthplace Georgia

16 (a) Informant Mrs Abbie L Young
(b) Address 1720 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Lawn
Location End of E 34th Ave

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins St

19 (a) MAY 16 1945 (Date received by registrar) (b) Huntington Woollcott, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15/1945, at 3.15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh W. B. Hagner M.D. Medical Examiner.

Date signed 5/15/45

G28919 — BALTIMORE CITY HEALTH DEPARTMENT — G28919

CERTIFICATE OF DEATH 193D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Mott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Ezel Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-01-8206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Married

6 (b) Name of husband or wife Mrs. Williams

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
50?			hr. min.

9. Birthplace North Carolina (Town, county and state)

10. Usual Occupation Ship cleaner

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Williams
(b) Address 413 - Mott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Joseph L. Young
(b) Address 804 N. Caroline St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to May 14 1945 and that I last saw h alive on 5/14 1945

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to H. C. V. D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Rolfes
Address Mercy Hosp. Date signed 5/19/45

X

G28920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G28920

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5501 Edmondson Ave.
(c) Hospital or institution:
Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5501 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (d) FULL NAME
GERTRUDE MASS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Edward F. Mass
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1871

8. AGE: Years	Months	Days	If less than one day
73	5	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name - Sexton
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Howard R. Mass
(b) Address 102 B St., N. E., Washington, D. C.

17 (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 16 1945
(a) (Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to May 14 1945 and that I last saw her alive on May 12 1945.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard R. Mass
Address 715 Frederick Ave Date signed 5/16 1945 M. D.

G28921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59

Registered No. G28921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hyen
(c) Hospital or institution: University hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Univ. Hospital
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Douglass
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/14/45

8. AGE: Years	Months	Days	If less than one day
29 days			hr. min.

9. Birthplace Univ. Hosp. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Joe Douglass
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Tennie Ratliff
15. Birthplace Balto. Md

16 (a) Informant Mother
(b) Address 1106 Leeden Hall.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 16 1945
18 (a) Funeral director Commissioner of Health
(b) Address
19 MAY 16 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13 1945 at 11 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1945 to 5/13 1945
and that I last saw h[illegible] alive on 5/13 1945
Immediate cause of death Resp. Failure

Duration

Due to Premature & Dehydration
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R C Cloninger M.D.
Address Univ. Hosp. Date signed 5/16/45
2705 Balto. Md.

VS 150

38922 — BALTIMORE CITY HEALTH DEPARTMENT — G28922

CERTIFICATE OF DEATH

159 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Hospital
(c) Hospital or institution Redwood + Green
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 A Westerway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dixon
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/13/45
8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.
9. Birthplace Union. Hosp. Balto. Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Dixon
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Florence Ripon
15. Birthplace Balto. Md

16 (a) Informant Father
(b) Address 13 A Westerway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 16 1945 (Date rec'd by registrar) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13/1945 at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13 1945 to 5/13 1945 and that I last saw h alive on 5/13 1945.

Immediate cause of death Resp failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R C Ellenberger M.D.
Address Union Hosp Date signed 5/14/45
Balto Md.

VS 150

2704

Dr Jul G28923
434 E 23 St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G28923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Simpson St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Simpson st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Seward

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-2-1868

8. AGE: Years	Months	Days	If less than one day
77	4.	2 12	hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Womply
15. Birthplace Va

16 (a) Informant Herbert Seward
(b) Address 2819 Simpson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 MAY 16 1945 (Date rec'd by registrar) (b) Huntington W Va Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to May 1945, and that I last saw h[illegible] alive on May 13 1945.

Immediate cause of death
Cerebral Hemorrhage
Hypertension
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman R. Julian, M.D.
Address 434 E. 23rd St Date signed 5/16/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G28924 — Registered No. G28924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] & Calvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible] Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lottie E. Martin (Verna May Martin)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife Mark E. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-74

8. AGE: Years 70 | Months [illegible]5 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business NONE

FATHER 12. Name John M. [illegible] RONEMOUS

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary A. Leaney

15. Birthplace Maryland

16 (a) Informant Son-Luther E. Martin

(b) Address 3100 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-45 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

(a) MAY 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 1945 at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1945 to 5-15 1945 and that I last saw h[illegible] alive on 5-15 1945

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to: Myocardial infarct

Due to:

Other Conditions Generalized Arteria Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon A. Snow M. D.

Address Union Memorial Hosp. Date signed 5-17-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G28925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mth.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Lutherton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Tremper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Tremper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/8/80

8. AGE: Years 64 | Months 6 | Days 4 6 | If less than one day hr. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Geo. Kahl
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Stumbaugh
15. Birthplace Md

16 (a) Informant Mrs. Chas. Kahl
(b) Address Lutherton P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Balto Co. Md

18 (a) Funeral director Kassabaum Funeral Home
(b) Address 240 E. Belair Ave.

MAY 16 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945 to May 14 1945, and that I last saw h[illegible] alive on May 14 1945.

Immediate cause of death Pulmonary Embolus (?)

Due to

Due to

Other Conditions Coronary Occlusion, Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brown M. D.

Address Sinai Hosp. Date signed 5/16/45

VS 180

JL - 29131 G28926 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G28926

CERTIFICATE OF DEATH V186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 -5
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 W. West St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Madock or Grace Maddox

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1862

8. AGE: Years	Months	Days	If less than one day
82	5	20	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jerome Lyon
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 17 (month) (day) 45 (year)
(c) Cemetery or crematory First Laurel Hill
Location Belmont Ave Pimlico Rd
18 (a) Funeral director Williams Cook Inc
(b) Address 1217 E. Fayette St
(c) Date rec'd by registrar MAY 16 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1937 to May 15 1945, and that I last saw h... or alive on May 15 1945.

Immediate cause of death Pneumonia — Duration 1 wk.
Due to
Due to
Other Conditions Arteriosclerosis - Senility
Fracture of Left Femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/2
(a) Accident, Suicide, or Homicide
(b) Date of occurrence 4/29/45 at 5 P M
(c) Where did injury occur? Baltimore (City or town) Balt. (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? City Hosp Infirm (Specify type of place) While at work? No
(e) Means of injury fell Mohair gutt... wd

23. Signature Harold S. Ba...
Address Balt. City Hosp. Date signed 5/16/45 M. D.

To be approved by the Medical Examiner
Approved: Robert Lee Graham M. D.

VS 150

[redacted] G28927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

[redacted] G28927

Registered No. [illegible]

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: S.S. Stanbrook, Pier X, Curtis Bay
(a) State (b) County
(c) City or town Liverpool, England (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cassidy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 25 | Months | Days | If less than one day hr. min.

9. Birthplace Liverpool Eng (Town, county, and state)

10. Usual Occupation Ships Carpenter

11. Industry or business SS Stan Lodge

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Luther Vic Grant
(b) Address Gillett Bldg

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Fayette St

19 (a) (Date received by Registrar) (b) Registrar

MAY 16 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 4:10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 5-15-45 at 4. a. M.
(b) Where did injury occur? City Harbor, Curtis Bay Pier X
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Boarding ship, fell from ladder.

23. Signature Howard J. Chaillis M.D. (Medical Examiner)
Date signed 5-18-45

X

G28928 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

[redacted] Registered No. G28928

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S. Vincent St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Peter Mayer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Elizabeth C Mayer
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 19 1885

8. AGE: Years	Months	Days	If less than one day
60	2	27	..... hr. ..... min.

9. Birthplace Hungary
(Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business B&O R.R.

FATHER
12. Name Unknown
13. Birthplace ,

MOTHER
14. Maiden Name ,
15. Birthplace ,

16 (a) Informant George J. Mayer
(b) Address 5916 Highgate Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/45 (month) (day) (year)
(c) Cemetery or crematory [redacted]
Location [redacted]

18 (a) Funeral director William Cook Inc
(b) Address 1217 W. Pratt St

19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 12 45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to Hypertensive Cardiovascular disease

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Greaton M.D.
Medical Examiner.
Date signed May 16 1945

VS 151

G28929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G28929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Lehigh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Edward Heath

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Hannah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18- 1875

8. AGE: Years	Months	Days	If less than one day
69	10	25	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation RETIRED ENEINEER
11. Industry or business

FATHER
12. Name William E. Heath
13. Birthplace WASHINGTON DC.?

MOTHER
14. Maiden Name Anna ? SMITH
15. Birthplace VIRGINIA?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 17/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAY 16 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13- 1945, at 7.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28- 1945, to 5-13- 1945 and that I last saw h. 1m alive on 5-13- 1945

Immediate cause of death	Duration
Coronary thrombosis.	5 days
Due to Arteriosclerotic heart disease	7
Due to	
Other Conditions Pulmonary Emphysema (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: on afore

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Date signed 5-13-45

VS 150

Huntington Williams, MD

G28930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

G28930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 Union Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Union Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Cornwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 5th 1868

8. AGE: Years	Months	Days	If less than one day
77	4	10	hr. min.

9. Birthplace Prince Wm Co. - Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Poole Engineering Co

FATHER
12. Name (Unknown) Cornwell
13. Birthplace "

MOTHER
14. Maiden Name Margie King
15. Birthplace Va

16 (a) Informant Anna Cornwell
(b) Address 1238 E. Lafayette Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 5/17/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Marys - Hampden
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) (Signature of local registrar) (b) Huntington, W. Va.

MAY 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14th 1944 to May 15th 1945 and that I last saw h alive on May 14th 1945;

Immediate cause of death Pneumonia

Duration

Due to Terminal Pneumonia complicating Hypostatic Congestion 4 days

Due to Senile Chronic Arterial Sclerosis Terminal Coronary Occlusion 2 years

Due to Heart disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. A. Leicht
Address 3614 Fairfield Rd. Date signed 5/16/45

X

G28931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 3 3 E

G28931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3435 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3435 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Larsen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth J. Larsen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1875

8. AGE: Years 70 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Norway (Town, county and state)

10. Usual Occupation Rigger (retired)

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18, 1945 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) MAY 17 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 44 to 5/16/45 19 and that I last saw h[illegible] alive on 5/15/45 19

Immediate cause of death: Multiple Myeloma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Williams, M.D.
Address 211 Quad Arts Bldg. Date signed 5/16/45

G28932 ✓ G28932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harris Lerner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Next Relative

(b) Address

17 (a) Burial (b) Date thereof 5-17-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philadelphia Road & Hamilton Ave

18 (a) Funeral director Jewish Funeral Chapel
(b) Address MAY 17 1945 Baltimore Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at 9.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1945 to 5-16 1945 and that I last saw him alive on 5-16 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature H. Edmund Levin

Address Levindale Date signed 5/17/45

VS 150

G28933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale Cove & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp. 2d
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 S. Monroe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry L. Goldberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days - | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mortyn Wahre
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael -
15. Birthplace Russia

16 (a) Informant Abraham Goldberg
(b) Address 210 S. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem. Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E. Balto St

19 (a) MAY 17 1945 (b) Registrar
(Date received by registrar)

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1945 to 5/16 1945 and that I last saw him alive on 5/16 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 hr.

Due to:

Due to Hypertensive C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor

Address WBGH Date signed 5/16/45

G28934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

G28934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4019 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Shafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjow Shafer
13. Birthplace Russia

MOTHER 14. Maiden Name Esther Paula
15. Birthplace Russia

16 (a) Informant Herbert E. Shafer
(b) Address 4019 Norfolk Ave

17 (a) Burial (b) Date thereof 5-17-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Brotherly Love
Location Jack Deere Inc

18 (a) Funeral director 1739 E. Balto St
(b) Address

19 (a) (Date rec'd by registrar) MAY 17 1945 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16- 1945, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10-1944 to May-16-1945 and that I last saw h[illegible] alive on May-16-1945

Immediate cause of death Carcinoma of Lungs — Duration about 9 months

Due to

Due to

Other Conditions none
(Include pregnancy within 3 months of death)

Date of operation Dec-20-44

Major findings of operation: Inoperable Carcinoma of left lung

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Herman Seidel M.D.

Address 2404 Entaw Pl Date signed 5/15/45

628935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

628935 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Hghts Ave
(c) Hospital or institution:
Mt Sinai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5804 Jonquil Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Milner

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Solomon Milner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
73	—	—	hr. — min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aaron Shustok
13. Birthplace Russia

MOTHER
14. Maiden Name Mietz Pruss
15. Birthplace Russia

16 (a) Informant David Milner
(b) Address 3531 Dorchester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rit - Carmel
Location

18 (a) Funeral director Louis Levin & Sons
(b) Address Baltimore St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 11:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to May 16 1945, and that I last saw her alive on May 16 1945.

Immediate cause of death Cerebral hemorrhage — Duration
Arteriosclerosis
Due to
Due to
Other Conditions Acute cardiac dilatation
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. Kadis M. D.
Address 7306 Eutaw Pl Date signed 5-16-45

VS 150

G28936 — Registered No. G28936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3536 Lyncheater Road
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto -
(If outside city or town limits write RURAL and give town)
(d) Street No. 3536 Lyncheater Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Weinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Israel Widow

6 (b) Name of husband or wife Israel Weinstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. H. W. Greene
(b) Address 600 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balti St

19 (a) MAY 17 1945 (Date rec'd by registrar) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 5-14 1945 and that I last saw h[illegible] alive on 5-14 1945

Immediate cause of death Hypertensive cardio-vascular disease.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin M.D.
Address 3400 Hilton Date signed 5/19/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28937 — AB-87651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G28937 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Givens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5- 1918

8. AGE: Years	Months	Days	If less than one day
26	10	9	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Izel Melvin
13. Birthplace N.C.

MOTHER
14. Maiden Name Florence Farley
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 922 [illegible] mont St.

19 (a) MAY 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14- 1945, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26- 1945 to 5- 14- 1945, and that I last saw h er alive on 5- 14- 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	18 mo.
Due to	
Due to	
Other Conditions Laryngeal t b c.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 5/15/45

G28938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G28938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4d
(e) Length of stay in Baltimore (yrs., mos., or days) ~~4d~~.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Hanover (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alfred W. Belbin

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Dora Belbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1858

8. AGE: Years	Months	Days	If less than one day
87	1	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or busine Hardwood Finisher

FATHER
12. Name Wm. Belbin
13. Birthplace England

MOTHER
14. Maiden Name Martha Davis
15. Birthplace England

16 (a) Informant Miss Adelaide Belbin
(b) Address 1516 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAY 17 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16-1945 at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2-1945 to 5-16 1945 and that I last saw him alive on 5-16-1945

Immediate cause of death Pulmonary edema — Duration

Due to Generalized arterio-sclerosis

Due to

Other Conditions Gangrene - left leg. Paget Disease (?)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. M. Shipley M. D.
Address University Hosp. Date signed 5-16-45

VS 150

Hunter Williams, M.D.

G28939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. G28939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp. 4 W 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Silver Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Katherine Beyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph F. Beyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1901

8. AGE: Years	Months	Days	If less than one day
44	1	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Busch
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Stark
15. Birthplace Germany

16 (a) Informant Mr. Joseph F. Beyer
(b) Address 2808 Silver Hill Ave.

17 (a) Burial (b) Date thereof 5/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 17 1945 Huntington Williams, MD
(Date rec'd) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1945 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13 1945 to 5/16 1945, and that I last saw her alive on 5/16 1945

Immediate cause of death	Duration
Cirrhosis of liver	
Due to hypertrophy	
Due to pancreatic	
Other Conditions Chronic alcoholism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David J. Taylor M.D.
Address W 38 St Date signed 5/16/45

G28940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3126 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MELVIN E. EVERSON

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia L. Everson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1869

8. AGE: Years 76 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Jamesville, Wisc.
(Town, county, and state)

10. Usual Occupation Printer - retired

11. Industry or business

FATHER
12. Name Ever Everson
13. Birthplace Norway

MOTHER
14. Maiden Name Andrella Olson
15. Birthplace Norway

16 (a) Informant Mrs. Julia L. Everson
(b) Address 3126 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945, at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1945, to May 15 1945, and that I last saw him alive on May 15 1945.

	Duration
Immediate cause of death Cerebral hemorrhage	3 days
Due to Arteriosclerosis	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2924 Brighton St. Date signed 5-17-45

VS 150

G28941
JL - 14005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28941
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 -0 - 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E, Witters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Murray Shilling
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Zellers
15. Birthplace York, Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave.

19 (a) (b) Huntington Williams
(Date received by registrar) Registrar

MAY 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1932, to May 15 1945, and that I last saw h er alive on May 15 1945.

Immediate cause of death	Duration
Cardiac insufficiency	A few Hours
Due to Arterio Sclerotic Heart Disease	
Due to	
Other Conditions Bronchopneumonia Gen arteriosclerosis	3 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Woodward M. D.
Address Baltimore City Hospital Date signed 5-16-45

X

G28942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28942 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 S.Collington Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S.Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Danielak

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-7242

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Josephine Danielak
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) ? 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business Mutual Chemical

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Josephine Danielak
(b) Address 219 S.Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-45 (month) (day) (year)
(c) Cemetery or crematory St.Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar) MAY 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/45 19 , to 5/15/45 19 , and that I last saw h/m alive on 5/15 1945

Immediate cause of death	Duration
Acute cardiac dilatation	1 day.
Due to Chronic myocarditis	10 yrs.
Due to Hypertension	10 yrs.
Due to arterio-sclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Wales M. D.
Address 47 Fulton Date signed

G28943 ✓ G28943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 E. Pratt Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Stawski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-6421

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age Deseased

7. Birth date of deceased (mo., day, yr.) ? 1869

8. AGE: Years 76 ? | Months | Days | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Dobrzyniewski
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Frank Stawski (Son)
(b) Address 2033 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore-Co., Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street, Huntington Station, Md.

19 (a) (b) Registrar

MAY 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1945, at 8:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1945, to May 15 1945, and that I last saw h-r alive on May 15 1945.

Immediate cause of death: Acute Br. Pneumonia — Duration: 1 wk

Due to: Primary

Due to:

Other Conditions: Acute Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac J. Staples M. D.
Address 2007 E. Pratt St. Date signed 5/16/45

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-1B

Registered No. G28944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. Balto Md. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 S. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosario Bonica.

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	M.	W.	M.

6 (b) Name of ~~husband~~ wife late Grazia Bonica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20. 1864.

8. AGE: Years	Months	Days	If less than one day
81	3	24.	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired ??
11. Industry or business

FATHER
12. Name John Bonica.
13. Birthplace Italy.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Carrie Pullano
(b) Address 1301 N Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14 1945 at 7 19 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945 to 5/14 1945 and that I last saw h/m alive on 5/14 1945

Immediate cause of death Pulmonary K
Cerebral metastasis &
generalized cachexia
Due to Carcinoma of
Prostate
Due to
Other Conditions Uremia.
(Include pregnancy within 3 months of death)

Duration
Months?
Years?
Weeks?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Wagerger M. D.
Address Mercy Hosp. Date signed 5/14/45

VS 150

28945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 E

Registered No. G28945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: De Chaul Home & Hospital, 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 S. Edaw St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME John De Zota
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Albina De Zota
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1872

8. AGE: Years	Months	Days	If less than one day
72	8	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Clothing Business

FATHER
12. Name John De Zota
13. Birthplace Italy

MOTHER
14. Maiden Name Katherine Calardo
15. Birthplace Italy

16 (a) Informant John De Zota
(b) Address 402 S. Edaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore
18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Marlyn Ave
MAY 17 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16-45, at 8:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1945, to 5-16 1945, and that I last saw h.r alive on 5-16 1945.

Immediate cause of death Pulmonary Oedema — Duration
Due to Coronaire Insufficiency
Due to Arterio-sclerotic Heart disease
Other Conditions Carcinoma of Buccal Membrane
(Include pregnancy within 3 months of death)
Date of operation 5-10-45
Major findings of operation Carcinoma of Buccal Membrane
of autopsy permission not asked

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James B. Lichfield M. D.
Address De Chaul Home & Hosp. Date signed 5-16-45

628946

BALTIMORE CITY HEALTH DEPARTMENT

TN. 93597

CERTIFICATE OF DEATH 44a

Registered No. 628946

Every item of information should be carefully supplied. Please write PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 E. Eager St ~~or Elder St~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Risher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1904

8. AGE: Years	Months	Days	If less than one day
41 ?	?	?	hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Risher (D
13. Birthplace S. C

MOTHER
14. Maiden Name Mary Priester
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Removal (b) Date thereof May 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Branchville S.C.

18 (a) Funeral director Mrs. Robert Elliott & Son
(b) Address 1129 N. Caroline St.

MAY 17 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th, 1945 19 , at 4.30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 19 45 to May 16 19 45
and that I last saw him alive on May 16 19 45

Immediate cause of death: Anemia — Duration ?

Due to Granuloma inguinale & urinary retention — Duration 2yrs 4wks

Due to extravasation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/9/45

Major findings of operations Urinary retention & extravasation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature E J Perry M.D.
M. D.
Address Baltimore City Hospitals Date signed 5/16/45

628947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. 628947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maria Roberta Gilbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1870

8. AGE: Years 75 | Months 3 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Bedford County Va. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Casey
13. Birthplace Va.

MOTHER
14. Maiden Name Maria ?
15. Birthplace Va.

16 (a) Informant Lottie Wood
(b) Address 2222 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Lottie A. Ellis
(b) Address 1297 N. Caroline St.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 15 1945 and that I last saw h... alive on May 15 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 15 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Johnson
Address 2329 Guilford Ave. Date signed May 17 1945

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G28918 Registered G28918

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write as directed. Use necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Round Hill Road
(c) Hospital or institution: G
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Round Hill Road
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Margaret Regina Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William J. Clarke
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	1	--hr. ---min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name William James Duffey
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret T. Hazelitt
15. Birthplace Baltimore, Maryland

16 (a) Informant Lieut. Joseph R. Clarke
(b) Address 1215 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's, Govans
Location Baltimore, Md.

18 (a) Funeral director H. D. Means and Son
(b) Address 805 N. Calvert Street

19 MAY 17 1945 (Date rec'd by registrar) (c) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slater M.D.
Medical Examiner
Date signed May 16 1945

X

CERTIFICATE CORRECTED 7-19-45

G28949

Registered No. G28949

CERTIFICATE OF DEATH 167

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Lancaster Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcos Pirovolos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) Birthplace

7. Birth date of deceased (mo., day, yr.) March 1895

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name George Pirovolos
13. Birthplace

MOTHER
14. Maiden Name Bezow
15. Birthplace

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 5-19-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd +

18 (a) Funeral director Lambros Funeral Home Inc.
(b) Address 440 E. North Ave.

19 (a) MAY 17 1945 Registrar for Milligan M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1945 at 11:45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of Chest & abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-15-45 at 9:45 P. M.
(b) Where did injury occur? Broadway & Lancaster St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed

23. Signature Robert Curtis Graham M.D.
Medical Examiner.
Date signed May 16, 1945

VS 151

G28950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G28950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 746 W Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 746 W Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Giedaitis

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Vincent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Vincent Giedaitis
(b) Address 746 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Belair Rd

18 (a) Funeral director Joseph Rasenskas
(b) Address 602 Washington Blvd

19 MAY 17 1945 (Date received by registrar) Huntington Woods, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945 at 5:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to May 16 1945, and that I last saw h— alive on May 16 1945.

	Duration
Immediate cause of death Acute Cardiac Dilitation	2 days
Due to	
Due to Chr. Myocarditis	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 25-32 W. Fayette St Date signed May 22/45

G28951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G28951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Barnes St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Barnes St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Annie Fisher
15. Birthplace Md.

16 (a) Informant Florence Dorsey
(b) Address 1424 Barnes St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 17 (day) 45 (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brandley Ave

19 MAY 17 1945 (Date rec'd by Reg.) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1945 to 5/13 1945 and that I last saw h[illegible] alive on 5/13 1945.

Immediate cause of death: Cerebral hemorrhage — Duration: days

Due to: Myocardial Degen

Due to: Chronic Nephritis

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Leporati

Address 532 W. Bro Date signed 5/16/45 M. D.

G28952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G28952

Every item of information should be carefully supplied. Write plainly, with UNFADING INK. Every question must be answered. If unknown or if the question is not applicable, state which. Do not use dashes or ditto marks. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 764 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) +7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 764 W. Mulberry
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Lena Easely Lewis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Alonzo Lewis

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 17, 1891

8. AGE: Years 53 | Months 9 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Orlando Thomas
13. Birthplace St. Marys Co. Md

MOTHER
14. Maiden Name Fannie Butler
15. Birthplace Washington, D.C.

16 (a) Informant Naomi Thomas Dorsey
(b) Address 764 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 16 45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Maryland

18 (a) Funeral director Mrs Ida Bagley
(b) Address 1421 Jefferson St

19 MAY 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 May 1945, at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1.3.45 19__ to 5.14.45 19__, and that I last saw her alive on 14 May 1945.

Immediate cause of death: Hypertensive heart disease — Duration: 1.3.45

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Lair
Address 400 N. Carrollton Date signed 5.16.45

X

G28953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G28953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto md
(c) Hospital or institution: Sinai Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 White Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUTHER M. Webber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1903

8. AGE: Years	Months	Days	If less than one day
41	6	5	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Martin Air Plant.

FATHER
12. Name George M. Webber
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Green
15. Birthplace Va.

16 (a) Informant Ruth W. Wood
(b) Address Lynchburg, Va.

17 (a) Removal (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Spring Hill Cem.
Location Lynchburg Va.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Pl.

MAY 17 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1945, to 5/16 1945, and that I last saw h.. alive on 5/16 1945.

Immediate cause of death Toxicity — Duration

Due to 80% burns 1st & 2nd 3rd degree

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc. 6/4
(b) Date of occurrence 5/16/45 at 11:30 P.M.
(c) Where did injury occur? 1906 E. Balto. St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? FRIEND'S HOME (Apt.) While at work? No
(Specify type of place)
(e) Means of injury Conflagration (house)

23. Signature Louis Sinai Hospital

Address Sinai Hospital Date signed M. 5 D. 17/45

For C. H. D. Mc Nally, by Homer J. Spaccia, M.D.

G28954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28954 Registered No. 109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Brenda Anne Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-45

8. AGE: Years | Months: 9 | Days: 11 | If less than one day: 12 hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Sterling Collins
13. Birthplace: ? Md

MOTHER
14. Maiden Name: Margie Sheppard
15. Birthplace: ? Md

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-45 (month) (day) (year)
(c) Cemetery or crematory: Johnsville
Location: Johnsville Carroll Co Md

18 (a) Funeral director: C. M. Wells
(b) Address: Winfield Md

19 (a) MAY 17 1945 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on May 16 1945.

Immediate cause of death: Dead on arrival - ? pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Leonard F. Kniffen Jr. M.D.
Address: Johns Hopkins Hosp. Date signed 5/16/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28955 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2542 Foster Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2542 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Jennie Nagle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	16 14	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name August
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Brem
15. Birthplace Baltimore Md.

16 (a) Informant Jennie Baker
(b) Address 2542 Foster Ave.

17 (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway Williamsport, Md.

19 (a) MAY 17 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13 1945, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1945 to 5/13 1945
and that I last saw h[illegible] alive on 5/11 1945

Immediate cause of death: Carcinoma of bladder — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Mortha F Mussoni M. D.
Address 1015 East Ave. Date signed 5/17/45

VS 180

Dr. Tankin G28956
100 N. Milton St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G28956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5006 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Rowley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1877

8. AGE: Years	Months	Days	If less than one day
68	3	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Rowley
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Hogan
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Boos
(b) Address 5006 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

MAY 17 1945 (Date filed) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th, 1945, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8th 1945, to May 16th 1945, and that I last saw h[e] alive on May 11th 1945.

Immediate cause of death	Duration
acute dilatation	5 days
Due to Cardio Vascular disease	2
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Tankin M.D.
Address 100 N. Milton Date signed 5/17/45

VS 150

Dr. Blum G28957 G28957

Preston & Harford

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 East Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 East Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Michael Joseph Davey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret Davey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	26	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Davey
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Davey
(b) Address 1014 East Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (b) MAY 17 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1945, to 5/15 1945, and that I last saw h. alive on 5/15 1945

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Renal Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1306 E. Preston St. Date signed 5/16/45

VS 150

G28958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

G28958 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 SOMERSET ROAD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 SOMERSET ROAD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES JANE FERGUSON

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife G.L.FERGUSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEBY 9, 1870

8. AGE: Years	Months	Days	If less than one day
75	3	7	hr. min.

9. Birthplace OHIO (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name ~~JOHN NEVIUS~~ ROBERT NEVIUS
13. Birthplace OHIO

MOTHER
14. Maiden Name ELIZABETH WILSON
15. Birthplace

16 (a) Informant STANLEY HUGHES
(b) Address 610 SOMERSET ROAD

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof MAY 18.45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE.

18 (a) Funeral director John O. Mitchell & Bro.
(b) Address 1300 EUTAW PLACE

19 (a) (Date rec[illegible] MAY 19 1945 (b) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 16.1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 19 45 to 5/16 19 45 and that I last saw her alive on 5/14 19 45

Immediate cause of death Carcinoma of rectum with Metastasis — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Holmes Dorsch M.D.
Address 24 E. EAGER ST. Date signed

X

G28959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G28959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Sq. Hosp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2238 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hardesty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1889

8. AGE: Years	Months	Days	If less than one day
56	3	2	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ele Hardesty
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Fobb
15. Birthplace Md

16 (a) Informant Laura Randall
(b) Address 2236 Penna Ave.

17 (a) Burial (b) Date thereof 5/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. G. Kelsan
(b) Address 1303 Pressman St

19 MAY 17 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16 1945 at 8 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1945 to 5-16 1945 and that I last saw h/ alive on 5-16 1945

Immediate cause of death Bronchopneumonia — Duration 2 days.
Due to Strangulated hernia — 7 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Strangulated hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Court Square Md Date signed 5/16/45 M.D.

X

G28960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G28960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 Presstman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Hynson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	M

6 (b) Name of husband or wife Mary C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1879

8. AGE: Years	Months	Days	If less than one day
65	9	15	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chas. Hynson
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. Jones
15. Birthplace Md

16 (a) Informant Mary Hynson
(b) Address 331 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

MAY 17 1945 (b) Huntington Ave Baltimore Md
(Date rec'd by Local Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1945, to 5/16 1945, and that I last saw h[illegible] alive on 5/16 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Neville

Address Provident Hospital Date signed May 16/45

X

G28961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V167

Registered No. G28961

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 5

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Asquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Carr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 Jan 1923

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Willie Carr
13. Birthplace N. C.

MOTHER 14. Maiden Name Lena Holland
15. Birthplace N. C.

16 (a) Informant Emily Crumley
(b) Address N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount N. C.

18 (a) Funeral director Hy. D. Kelson
(b) Address 1303 Pressman St

19 (a) MAY 17 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 11:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/16/45 at 1:45 A. M.
(b) Where did injury occur? 115 S. Bond St.
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's House While at work? No.
(d) Means of injury Stabbed during altercation

23. Signature Robert L. Fontaine M.D.
Medical Examiner
Date signed May 18 1945

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied. The

G28962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

G28962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5311 Belleville Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5311 Belleville Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Capt. Benjamin Franklin Seipp

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Margaret Seipp
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) November 4, 1877

8. AGE: Years	Months	Days	If less than one day
67	6	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Captain - Retired
11. Industry or business Baltimore City Fire Dept.

FATHER
12. Name Benjamin F. Seipp
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Elizabeth Barry
15. Birthplace England

16 (a) Informant Mrs. E. Margaret Seipp
(b) Address 5311 Belleville Ave.

17 (a) Burial (b) Date thereof May 19, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 1500 Liberty Heights Ave.

19 (a) MAY 17 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 5.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1945 to May 16 1945, and that I last saw him alive on 5/15 1945.

Immediate cause of death	Duration
(a) Uraemia	
Due to (b) Chronic nephritis	
Due to (c)	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Wolinsky M. D.
Address 4710 Liberty Hgts Ave Date signed

1317

G28963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178a

G28963
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5434 Wesleyan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Lizotte

3 (b) If veteran, name war

3 (c) Social Security Account No. 072-09-8709

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1891

8. AGE: Years 53 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Calumet, Mich.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Furniture Contr'g Co

FATHER
12. Name Edward Lizotte
13. Birthplace Canada

MOTHER
14. Maiden Name Argelie Lussier
15. Birthplace Canada

16 (a) Informant John B. Lizotte
(b) Address Frederick Md.

17 (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Frederick Md.

18 (a) Funeral director Hilbert & Eichelberger
(b) Address 127 E. Lexington St.

19 (a) MAY 17 1945 Huntington Williams M.D.
(Date received) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 8:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy
Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 13 1945 10 P.M.
(b) Where did injury occur? 5434 Brooklyn Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas from defective pipes

23. Signature Richard Ch. Fratcher M.D.
Medical Examiner.
Date signed May 16 1945

VS 151

corrections or information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G28964 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G28964

CERTIFICATE OF DEATH

✓160a

1. PLACE OF DEATH — Registered No. .....

CITY OF BALTIMORE: (No. Volunteers of America Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 9 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Jeanette Alice Moeller — If U. S. Veteran specify WAR .....

(a) Residence: No. 1113 S. Paca St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) May 8 1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) Balto (State or country) Md

FATHER

13. NAME Donald Moeller

14. BIRTHPLACE (city or town) Balto (State or country) Md.

MOTHER

15. MAIDEN NAME Eva Wetzel

16. BIRTHPLACE (city or town) Balto (State or country) Md

17. INFORMANT Eva Moeller
(Address) 1113 S. Paca St.

18. BURIAL, CREMATION, OR REMOVAL
Place UNIVERSITY MEDICAL SCHOOL MAY 17 1945 19.

19. UNDERTAKER Commissioner of Health
(Address)

20. MAY 17 1945 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 16, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 8, 1945, to May 16, 1945

I last saw her alive on May 16, 1945. Death is said to have occurred on the date stated above, at 2.30 p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Lemorrhage	5/16/45
Other contributory causes of importance:	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) Bernard Epps M. D.

(Address) Volunteers Hosp. 5/17/45

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS B

2708 X

G28965

Blaney

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G28965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Howard sts
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto. (b) County
(c) City or town Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 W. Lanvale Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anita Blaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John Blaney
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Maryland, Balto (Town, county, and state)
10. Usual Occupation R. N.
11. Industry or business

FATHER
12. Name Charles Mewshaw
13. Birthplace Mary Land

MOTHER
14. Maiden Name Agnes Barnes
15. Birthplace Ireland

16 (a) Informant John J. Blaney, Jr
(b) Address 919 N. Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)
(c) Cemetery or crematory Catholic Cem.
Location

18 (a) Funeral director Mary M. Kirkfield
(b) Address 52[illegible] E. Baltimore St

MAY 17 1945 (b) Contractor Williams M[illegible]
Date rec'd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945 at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to May 15 1945, and that I last saw h[illegible] alive on May 13 1945

Immediate cause of death: Cholemia — Duration 2 wks

Due to Generalized Carcinomatosis involving liver — 3 mos

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Pelan MD

Address Mercy Hosp. Date signed 5/16/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JO #93619 G28966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √/31a

Registered No. G28966

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6648 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ransom Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1874

8. AGE: Years	Months	Days	If less than one day
71 70 ?	?	?	hr. min.

9. Birthplace Unable to obtain further information (Town, county, and state)
10. Usual Occupation "
11. Industry or business "

FATHER
12. Name " " " "
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address, 4940 Eastern Avenue

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Gallagher Funeral Co
(b) Address 1219 E Fort Ave

19 (a) MAY 17 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1945 at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1945 to May 16, 1945. and that I last saw him alive on May 15, 1945.

Immediate cause of death	Duration
Coronary Thrombosis.	2 days
Due to Arteriosclerotic heart disease.	?
Due to Bronchopneumonia.	R
Other Conditions Nephrosclerosis. Cardiac Failure	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Date signed 5-17-45

930 G28967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28967 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrey Kozirka or Andy Koziko

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-3167

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1885 ?

8. AGE: Years	Months	Days	If less than one day
59 ?	10	11	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Driller
11. Industry or business Bethlehem Steel

FATHER
12. Name Jacob Kozika or Kozirka
13. Birthplace Russia

MOTHER
14. Maiden Name Mary ?
15. Birthplace Russia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial — (b) Date thereof May 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Innocents Cemetery
Location Dundalk, Md.
18 (a) Funeral director Randall Chapel
(b) Address 2 Liv. St.
19 (a) (Date) Filed by registrar May 17 1945 Harrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1945, at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 9, 1945, to May 15, 1945, and that I last saw h im alive on May 14, 1945.

Immediate cause of death	Duration
Cachexia	1 month
Bronchopneumonia	1 wk.
Due to Tumor of Brain	?
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Bronchopneumonia, Tumor (Brain)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was [illegible] following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hauck E. Balto M. D.
Address Balt. City Hosp. Date signed 5/18/45

G28968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G28968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Woodhaven Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Woodhaven Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES M. CASHMAN

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William E. Cashman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 2, 1871

8. AGE: Years 73 | Months 10 | Days 14 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Miller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Rose Schirmer
15. Birthplace: Germany

16 (a) Informant: Mr. William E. Cashman
(b) Address: 4008 Woodhaven Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 19 1945 (b) Huntington Mills Reg. M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1945, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1944, to May 16 1945 and that I last saw h[illegible] alive on May 15 1945

Immediate cause of death — Duration

Due to: Carcinoma of Liver — 1 year

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: M. L. Gibney M.D.
Address: 6 W Mt Vernon Pl Date signed: 5/17/45

VS 150

X

G28969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G28969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jefferson Apts.
(c) Hospital or institution: Lidle Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E. 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Lipsky

3 (b) If veteran, name war | 3 (c) Social Security Account No. 710

4. Sex M | 5. Color or race W | 6 (a) Single, married, ~~widowed~~ or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1895

8. AGE: Years	Months	Days	If less than one day
49	10	25	hr. min.

9. Birthplace S. Hamolein Ru (Town, county, and state)
10. Usual Occupation Mgr. Cannon Shoe Co
11. Industry or business

FATHER
12. Name Nathan Lipsky
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Kline
15. Birthplace Russia

16 (a) Informant Harry Lipsky
(b) Address 506 Jefferson St

17 (a) Removal (b) Date thereof 5/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Allentown
Location Pennsylvania

18 (a) Funeral director Wm. J. Luckner & Sons
(b) Address N. E. Potomac Ave. Balto. Md.

MAY 18 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945, at 10 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1945 to May 17 1945, and that I last saw h.l.m. alive on May 17 1945.

Immediate cause of death: Cardio-respiratory failure

Due to Myocardial failure

Due to Coronary thrombosis Coronary insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary sclerosis Myocardial infarction

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Leuchter M.D.
Address Sinai Hosp. Date signed 5-17-46

G28970

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G28970 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Newington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H B. Singer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M

6 (b) Name of husband or wife Emily Singer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/1887

8. AGE: Years	Months	Days	If less than one day
57 57	5	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Mutual Clerk

11. Industry or business Cemetery Race Track

FATHER
12. Name John F Singer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah Bosley
15. Birthplace Baltimore

16 (a) Informant Mrs Mary M. Singer
(b) Address 2412 N. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Freedom Ave

18 (a) Funeral director H. J. Pokey Sons
(b) Address 1 N Eutaw St.

19 (a) MAY 18 1945 (Date rec'd by registrar) (b) Huntingtown Calvert Co. Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945, at 1 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gratton M.D. Medical Examiner.
Date signed May 17 1945

X

G28971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G28971
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Arbutus.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Circle Drive (DRIVE)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Robert Lowman

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1941

8. AGE: Years	Months	Days	If less than one day
3	7	12	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Aubrey L. Lowman
13. Birthplace Brooklyn Md.

MOTHER
14. Maiden Name Dorothea Milan
15. Birthplace Baltimore Md.

16 (a) Informant Aubrey L. Lowman
(b) Address 1713 Circle Drive Arbutus

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave

19 (a) (b)
MAY 18 1945
Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16/45 19.. at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16/45 19.. to 5/16/45 19.. and that I last saw h/im alive on 5/16/45 19..

Immediate cause of death	Duration
Coma	
Due to Peritonitis	16 hrs.
Due to Ruptured Appendicitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/16/45
Major findings of operation: Ruptured Appendix; Diffuse Peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.
23. Signature Albert D. Adams, M. D.
Address West Baltimore General Hospital Date signed 5/16/45

X

G28972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G28972 Registered No.

JO #93296

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Bevans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Permetta Gillard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1926

8. AGE: Years	Months	Days	If less than one day
19	2	14	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Henry Gillard
13. Birthplace Georgia

MOTHER
14. Maiden Name Marie Richardson
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Pinkroke Ga

18 (a) Funeral director Isaiah A Brown Son
(b) Address 108 W Montgomery St

19 (a) (Date rec'd by registrar) (b) Huntington Inman Registrar

VS 150 MAY 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 25, 1945 to May 16, 1945 and that I last saw h er alive on May 15, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	3 mo.
Due to	
Due to	
Other Conditions. Tuberculosis of liver (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 6/17/45

G28973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 S. Rose Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 S. Rose Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARYANNA SROKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Joseph SROKA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Anthony Pruchniewski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Tillie Sobczynski
(b) Address 720 S. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. County

18 (a) Funeral director John M. Webber
(b) Address 1111 S. Chester St
MAY 18 1945 (Date rec'd by registrar) Huntington Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to May 16 1945 and that I last saw h.r alive on May 16 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 5/16/45

Due to Arterio Sclerosis — 1936

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Rosar M. D.
Address 801 N. Kenwood Ave. Date signed 5/16/45

VS 150

G28974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G28974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Tyson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 MAY 18 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17 1945 at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Varicose ulcers

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally Medical Examiner.
Date signed 5/19/45

G28975 Saf

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

G28975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Calbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/45

8. AGE: Years	Months	Days	If less than one day
0	0	7	hr. 16 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 5/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b) MAY 18 1945
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945, to May 10 1945, and that I last saw h[illegible] alive on May 9 1945.

Immediate cause of death Resp failure

Due to Acidosis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

(f) Signature Charles O. Chaplet M. D.
Address Univ. Hospital Date signed 5/11/45

X

ASCo. 1-31 2198

PETTIE

HEALTH DEPARTMENT—CITY OF BALTIMORE

G28976 G28976

CERTIFICATE OF DEATH 92B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 Harlem Ave St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Annie Parker Pettie

(a) Residence: No. 829 Harlem Ave St., Ward. 17-3
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	Colored	Widows

6. If married, widowed, or divorced HUSBAND of (or) WIFE of John Pettie

6. DATE OF BIRTH (month, day, year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. general
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Alfred Dunlavy
14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME ?
16. BIRTHPLACE (city or town) (State or country) Virginia

17. INFORMANT Ruby Pettie daughter
(Address)

18. BURIAL, CREMATION, OR REMOVAL. Place Mt Auburn Date May 18, 1945

19. UNDERTAKER Mrs Katie R Williams
(Address) 3-22 1945 Lucas St

MAY 18 1945

20. FILED 19 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 15, 1945

I HEREBY CERTIFY, That I attended deceased from March 15, 1945 to May 15, 1945

I last saw h[illegible] alive on May 14, 1945 death is said to have occurred on the date stated above, at 1:15 A m.

The principal cause of death and related causes of importance were as follows:

Acute Mitral Stenosis

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) H Stewart X M. D.

(Address) 3-22 Franklin St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G28977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1943 Registered No. G28977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015-N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick R. Buck

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife — Ida R. Buck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1867

8. AGE: Years 77 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Charles F. Buck
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Margaret —?
15. Birthplace Balto. Md

16 (a) Informant Mrs. Margaret DeVilbiss
(b) Address 3816 Hedgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. (a) (Date rec'd by registrar) 5/19/45 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5th 1945 to May 16 1945, and that I last saw him alive on May 16 1945.

Immediate cause of death Resp. failure — Duration

Due to Arteriosclerotic P.V.H.D. & Uremia

Due to

Other Conditions Pyo. Malignancy of Lung

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. R. Rolfes M. D.
Address Date signed 5/19/45

VS 180

G28978

G28978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 Shelburne Rd.
(c) Hospital or institution:

27-220

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Shelburne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY A. JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Cora V. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1865

8. AGE: Years	Months	Days	If less than one day
79	7	17	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Md. Jockey Club

FATHER
12. Name -- Jones
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Ethel Nugent
(b) Address 3319 Shelburne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 18 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3rd 1944, to May 17th 1945, and that I last saw him alive on May 15th 1945.

Immediate cause of death	Duration
Chronic Myocarditis	1 yr.
Due to Coronary Sclerosis	5 yrs
Due to Art. Sclerosis	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James A. Miller M.D.
Address Pikesville, Md. Date signed 5/18/45

VS 150

C-28979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. C-28979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilton St.
(c) Hospital or institution:
Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1664 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES E. HUGGINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise B. Huggins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1869

8. AGE: Years	Months	Days	If less than one day
75	8	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Paper Hanger
11. Industry or business

FATHER
12. Name William Huggins
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Susan J. Eckert
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Elsie Lohmeyer
(b) Address 613 N. Payson St.

17 (a) Burial (b) Date thereof 5/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 18 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May 17, 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945 to May 16 1945 and that I last saw him alive on May 16 1945.

Time. Date cause of death	Duration
(a) Arteriosclerotic C-V disease	
Cerebral Hemorrhage	3 hrs/45
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Lowy, M.D.
Address 1844 W. North Ave. Date signed 5/18/45

VS 130

G28980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G28980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Court Apts. 2111 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA E. TAYLOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Oscar S. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1864

8. AGE: Years	Months	Days	If less than one day
80	10	18 28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Coyle
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Rhodes
15. Birthplace Md.

16 (a) Informant Mrs. Robert Morrow
(b) Address 2103 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 9 1945 to May 16 1945; and that I last saw h alive on May 14 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	1 day
Due to Arteriosclerosis	years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Bruce Marshall M. D.
Address 2200 Garrison Blvd Date signed 5-17-45

VS 150

G28981

BALTIMORE CITY HEALTH DEPARTMENT

TN. 93642

CERTIFICATE OF DEATH

Registered No. G28981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6303 Toone St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

22743

3 (a) FULL NAME Corrine Dewald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 4 ?15 1945

8. AGE: Years | Months 1 | Days 2 weeks | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Dewald
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Cocu
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Donnell st

18 (a) Funeral director Mary E. Piakowski
(b) Address 1500 S. Kenwood Ave

19 (a) 5-8 1945 Huntington Williams M.D. (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th, 1945 19 at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16th, 1945 to May 16 1945, and that I last saw her alive on May 16 19 45

Immediate cause of death: Septicemia due to
Due to: unidentified
Due to: organism
Other Conditions: & hl edema
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: retachal hemorrhage
of autopsy: no plasma t was related

Duration: 8 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Burmingham M. D.
Address BCH Date signed 5-17

VS 150 SUBJECT TO APPROVAL OF THE MEDICAL EXAMINER, by Howard J. Haeger, M.D.

G28982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G28982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 N. Ellwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alvina Kloiber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife ~~xx~~ Jacob Kloiber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1885

8. AGE: Years	Months	Days	If less than one day
60 yrs.	3	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Maurer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Galster
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marie Rose - daughter
(b) Address 82 Kingston Park

17 (a) Burial (b) Date thereof 5/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 MAY 18 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 10 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to May 15 1945 and that I last saw h-- alive on May 15 1945.

Immediate cause of death Carcinoma of Cervix & metastasis — Duration 3 years

Due to

Due to

Other Conditions Perforation Appendix 5 days prior to death

Major findings of operation: Carcinoma of Cervix

Date of operation

(Include pregnancy within 3 months of death)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Schimunek M.D.
Address 2939 E. Monument Date signed 5/17/45

G28983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

Registered File No. G28983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E. RANDALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 E. RANDALL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ISAAC B. LAIRD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife LYDIA A. HADAWAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 17. 1876

8. AGE: Years	Months	Days	If less than one day
68	6	2	hr. min.

9. Birthplace Somerset Co. Md.
(Town, county, and state)
10. Usual Occupation Packing Business, Wm Grecht
11. Industry or business Fruit packers

FATHER
12. Name FRANK LAIRD
13. Birthplace MD.

MOTHER
14. Maiden Name MARY WILSON
15. Birthplace MD.

16 (a) Informant EDNA L. GRECHT
(b) Address 6 E. RANDALL ST.

17 (a) BURIAL (b) Date thereof May 20. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SHERWOOD CEMETERY
Location SHERWOOD, TALBOTT CO. MD.

18 (a) Funeral director John O. Stabell & Sons
(b) Address 1900 EUTAW PLACE

19 (a) MAY 19 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 17. 1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945 to May 17 1945 and that I last saw h alive on May 17 1945

Immediate cause of death – Angina Pectoris — Duration 6 mos

Due to Arterio Sclerosis — 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. B. Whittle M. D.

Address 1279 William St. Date signed

X

G28984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G28984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Sargeant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin Stricker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 56 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation FOREMAN (MT CLAIRE SHOP)

11. Industry or business B+O RR.

FATHER 12. Name ANTON STRICKER

13. Birthplace GERMANY.

MOTHER 14. Maiden Name MARGARET KOENER

15. Birthplace BALTIMORE MD

16 (a) Informant GEORGE STRICKER

(b) Address 1274 BATTERY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS. CEM

Location A A Co.

18 (a) Funeral director Bernard D Hartle

(b) Address 121 E West St

19 (a) (Date received by Local Registrar) (b) Huntington Williams M.D.

MAY 18 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed May 17 1945

X

G28985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G28985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 Orleans Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Orleans Street (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marcus Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-8754

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband~~ and or wife Ruth (nee Lawton)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1901

8. AGE: Years 44 yrs. | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation

11. Industry or business Bethleham Stoel

FATHER
12. Name Marcus Weaver
13. Birthplace Millerburg, Penna.

MOTHER
14. Maiden Name Minnie S. Houdeshell
15. Birthplace Marysville, Penna.

16 (a) Informant Ruth E. Weaver - wife
(b) Address 1708 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Oakdawn
Location Balto

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) MAY 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945 to May 16 1945 and that I last saw h alive on May 16 45.

Immediate cause of death: Coronary Occlusion — Duration: 3 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny
Address 2200 E Madison St Date signed 5/18/45

Howard F. Mencken, M.D.

628986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 628986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4500 - Bannin Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio Serio

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Rosa Palmisano
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 5, 1877

8. AGE: Years 67 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Serio
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Serio
15. Birthplace Italy

16 (a) Informant James N. Serio
(b) Address 3808 - Dorfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 - 45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director Frank P. Pipitone
(b) Address 2815 E. Baltimore Md

19 (a) MAY 18 1945 (Date received by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to May 16 1945 and that I last saw b alive on 19

Immediate cause of death Hypertension C.V.R.D. Cardio vascular renal disease — Duration 5 yrs

Due to

Due to

Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Roper

Address Date signed 5/16 M.D.

VS 150

D28987

BALTIMORE CITY HEALTH DEPARTMENT ✓ D28987

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 S.DURHAM ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 22 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 S.WOLFE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LUCY S.PETERSON
3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: HENRY PETERSON
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) MAY 19 1874
8. AGE: Years 70 Months 11 Days 29 If less than one day hr. min.
9. Birthplace LONG ISLAND NEW YORK (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ? PEDERICK
13. Birthplace N.Y.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace N.Y.

16 (a) Informant NINA BLACHOWICC(DAUGHTER)
(b) Address 411 S.DURHAM ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 19/45 (month) (day) (year)
(c) Cemetery or crematory MT.CARMEL
Location ODONNELL ST.

18 (a) Funeral director Tully & Foster Co.
(b) Address 403 S.WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH MAY 17 1945 at 3/03 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-1 1945 to May 17 1945 and that I last saw alive on May 16 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 10 days

Due to: Cerebral Arteriosclerosis ? Hypertension

Due to:

Other Conditions: Diabetes

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.

23. Signature Mary J. Douglas M.D.
Address 700 E. Fayette St. Date signed 5/18/45

VS 150

83a

G28988 ✓ G28988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2843 Chesterfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2843 Chesterfield
(If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Horst

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Thomas Horst

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1878

8. AGE: Years 67 | Months 2 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

MOTHER / FATHER

12. Name H Louis Schmidt

13. Birthplace Germany

14. Maiden Name Henrietta Leidner

15. Birthplace Germany

16 (a) Informant Mrs Emma Ebersberger

(b) Address 2229 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)

(c) Cemetery or crematory Oaklawn Cem

Location Balto Md

18 (a) Funeral director Ulrich Fitzgerald

(b) Address 200 E. Orleans St

19 (a) (Date received) MAY 18 1945 (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at 11.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13/45 1945 to 5/16 1945, and that I last saw h[illegible] alive on 5/16/45 1945.

Immediate cause of death — Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Amelia E. Link

Address 2211 E Lake Ave Date signed 5/18/45 D.

G28989

BALTIMORE CITY HEALTH DEPARTMENT

469417 CERTIFICATE OF DEATH 13B

G28989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 - 22 1/2 St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Mason.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-14

8. AGE: Years	Months	Days	If less than one day
30	5	10	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Vulcanizing

11. Industry or business

FATHER 12. Name Rudy Mason

13. Birthplace Va

MOTHER 14. Maiden Name Harriet Robinson

15. Birthplace Va

16 (a) Informant Rennda.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)

(c) Cemetery or crematory

Location Portsmouth - Virginia

18 (a) Funeral director Mrs. Frances H. Hennessy

(b) Address 578 W. Bute St.

19 MAY 18 1945 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 18 1945, at 12.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945, to May - 18 1945, and that I last saw him alive on May - 18 1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Constriction pericarditis

Due to tuberculous mediastinitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 19, 1945

Major findings of operation: Thickened calcified pericardium

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellen Leymaster M. D.

Address Johns Hopkins Hosp Date signed 5/18/45

G28990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

Registered No. G28990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard sts.
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Pearl St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carrie Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-1896

8. AGE: Years 49 | Months 3 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER 12. Name Berry Allen

13. Birthplace S.C.

MOTHER 14. Maiden Name Joan Maxwell

15. Birthplace S.C.

16 (a) Informant Lillian Warren

(b) Address 775 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 20 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A. Jackson

(b) Address 216 Pennsylvania Ave Balto Md

19 MAY 18 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1945 at 7:7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1945 to 5/16 1945, and that I last saw her alive on 5/14 1945.

Immediate cause of death Heart Failure — Duration

Due to Hypertensive C-V Disease

Due to

Other Conditions Auric Fibrillation C-V Accident (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Hedberg Jr. M. D.

Address Univ Hosp Date signed 5/17

VS 150

G28991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G28991 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Nathaniel Wilkens

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 226-07-6771

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1885

8. AGE: Years	Months	Days	If less than one day
60 ??	?	?	? hr. ? min.

9. Birthplace Virginia Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Robert Clay Wilkens
13. Birthplace Virginia Va

MOTHER 14. Maiden Name Joanna Boyster
15. Birthplace Virginia Va

16 (a) Informant Willie Wilkens
(b) Address 279 Macon St. Brooklyn

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 5-18-45 (month) (day) (year)

(c) Cemetery or crematory Blenford Cemetery
Location Petersburg Va

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) 5-18 1945 (Date registered) Huntington Williamsville (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945, to May 16 1945, and that I last saw h... alive on May 16 1945.

Immediate cause of death	Duration
Dehydration	
Due to Bulbar Polio	
Due to Pneumonia	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Finnegan M. D.
Address University Hosp. Date signed May 17, 1945

VS 150

G28992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

Registered No. G28992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Warner Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Warner Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alphonso Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 1945

8. AGE: Years	Months	Days	If less than one day
	1	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER
12. Name Alphonso Wise
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ann Kelly
15. Birthplace Baltimore Md

16 (a) Informant Alphonso Wise
(b) Address 706 Warner Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.Co. Md

18 (a) Funeral director Joseph L. Brocato Jr.
(b) Address 1048 Montgomery Street

19 (a) MAY 19 1945 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 45 - 1:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Enlargement of Thymus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D. Medical Examiner.
Date signed May 18 1945

X

G28993

NO #93578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G28993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs. 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1891

8. AGE: Years 53 54 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Hughes (d)
13. Birthplace South Carolina

MOTHER
14. Maiden Name Isabella Pellam (d)
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Co Md

18 (a) Funeral director Isaiah L Burnett
(b) Address 101 W Montgomery St.

MAY 19 1945 (b) Huntington Williams Registrar
Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11, 1945 to May 12, 1945, and that I last saw him alive on May 12, 1945.

	Duration
Immediate cause of death Congestive heart failure	7
Due to arteriosclerotic heart disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No not

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M.D.
Address 812 Leadenhall St. Date signed 5-18-45

VS 150

G28994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 B

G28994 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W.
(b) Street address 750 W Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W. Balto. St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles K. Bales

3 (b) If veteran, name war

3 (c) Social Security Account No. 233-14-7468

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Virgie Bales

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2nd 1912

8. AGE: Years 33 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Bethlehem Steel Co

FATHER
12. Name Henry Bales
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Sweeney
15. Birthplace Va.

16 (a) Informant Virgie Bales
(b) Address 750 W. Balto. St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Monaker
Location Virginia

18 (a) Funeral director William Bok Inc
(b) Address 1217 St. Paul St.

19 (a) MAY 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1945 at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D. Medical Examiner.
Date signed May 18, 1945

VS 151

G28995

BALTIMORE CITY HEALTH DEPARTMENT ✓ G28995

CERTIFICATE OF DEATH 126

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1014 Herndon Ct Brooklyn (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Morell
3 (b) If veteran, name war
3 (c) Social Security Account No. 263-22-4578
4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Morell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 20th 1901
8. AGE: Years 43 | Months 8 | Days 27 | If less than one day: hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Fairfield Shipyard

FATHER
12. Name Francesko Azzati
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary B. Morell Wife
(b) Address 1014 Herndon Ct. Brooklyn 25 Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery Cedar Hill
Location A.A. Co. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
19 (a) 5/19/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 - 1945, at 3.40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1945 to 5-17 1945, and that I last saw him alive on 5-17 1945

Immediate cause of death: Heart Failure — Duration
Due to: Mediastinal Shift
Due to: Lobectomy rt
Other Conditions: TBc

(Include pregnancy within 3 months of death)
Date of operation Apr. 23-45
Major findings of operation: TBc Empyema.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. Frenkhouse M. D.
Address Redwood & Green Date signed 5-22-45

VS 150

X

G28996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G28996

Registered No.

Every item of information should be carefully supplied; write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2108 McCulloh St
(b) Street address Baltimore, Maryland
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Mc Culloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Price

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace New York N. Y.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Robert A. Price
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lula Smith
15. Birthplace Cockeysville, Md

16 (a) Informant Lula Price
(b) Address 2108 Mc Culloh St

17 (a) Burial (b) Date thereof May 19, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Colored Mem. Pk
Location Balto. Co. Md.

18 (a) Funeral director Wm. Chas. H. Miller
(b) Address 1631 Druid Hill Ave.

19 (a) (Signature) (b) Huntington Williams Reg. No.

MAY 19 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945, at P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of the Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed May 19, 1945

X

G28997 Ellis

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 15

Registered No. G28997

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 George st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 George st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Dixon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2- -1922.

8. AGE: Years	Months	Days	If less than one day
23	-3	—	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Jim Dixon
13. Birthplace Va

MOTHER 14. Maiden Name Hattie Stephens
15. Birthplace Va

16 (a) Informant Louis Dixon
(b) Address 625 George st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 216 Pennsylvania ave

19 MAY 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/45 1945 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17/45 to 5/17/45
and that I last saw h— alive on 5/17/45

Immediate cause of death Tuberculosis Peritonitis — Duration —
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —
23. Signature [illegible] M. D.
Address [illegible] Date signed 5/19/45

X

628998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

628998

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 Wayne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Parker Scott, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-6680

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna E. Ningard Scott
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) January 8, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Photographer
11. Industry or business Gas & Electric Co.

FATHER
12. Name William R. Scott
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Georgianna Elliott
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Edna E. Scott
(b) Address 2909 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director [illegible]
(b) Address 4510 Liberty Heights Ave.

MAY 19 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to May 17 1945; and that I last saw him alive on May 17 1945.

Immediate cause of death	Duration
Coronary Thrombosis	14 hours
Due to Arteriosclerosis	5 years
Due to	
Other Conditions Angina Pectoris	20 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Liberty Hgts Ave Date signed

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

G28999 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Elmira Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Elmira Av. (If rural give location)
(e) Citizen of foreign country? ELMIRA AVE (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 1866

8. AGE: Years	Months	Days	If less than one day
78 79	9		hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Stone moulder
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace md.

MOTHER
14. Maiden Name Carolyne
15. Birthplace md.

16 (a) Informant Wesley Wilson
(b) Address Rumsey St + Campbell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Edward Foulger
(b) Address 2363 West Baltimore St

19 (a) (Date rec'd by Local Registrar) MAY 19 1945 Registrar

VS 11-1

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1945, at 10-20 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNulty M.D.
Medical Examiner.
Date signed 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G29000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G29000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Wilmot Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1015 Wilmot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L Ellis

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Revicca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1859

8. AGE: Years 86 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Claiborne Co - Tenn (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name London Ellis
13. Birthplace

MOTHER
14. Maiden Name Mary
15. Birthplace Tenn

16 (a) Informant Mary E Miller
(b) Address 1015 Wilmot Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 1945 (month) (day) (year)
(c) Cemetery or crematory New Post Mason Va
Location Va

18 (a) Funeral director Wm A Cook Inc
(b) Address 1948 Huntington Ave Baltimore Md

19 (a) MAY 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 1.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1938 to May 18 1945.
and that I last saw h.. alive on May 18 1945

Immediate cause of death: Uremia — Duration

Due to Cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E North Ave Date signed 5/19/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29001

Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 dys
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Front St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward Rose

3 (b) If veteran, name war

3 (c) Social Security Account No. 064-14-4580

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Rosia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1900

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace East Atkins Pa. (Town, county, and state)

10. Usual Occupation U.S. Sailor.

11. Industry or business

FATHER 12. Name George W. Rose

13. Birthplace Pa.

MOTHER 14. Maiden Name Carrie L. Dibble

15. Birthplace Pa

16 (a) Informant George Rose.

(b) Address Atkins Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19th 1945 (month) (day) (year)

(c) Cemetery or crematory.....

Location Sayre Penna.

18 (a) Funeral director Leo B. Crook

(b) Address 1701-03 N. Patterson Park Ave

19 (a)..... (Date rec'd by registrar) MAY 19 1945 (b) Huntington Williams, M.D. Registrar

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1945 at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia

Due to Chronic Nephritis

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Robert Lee Foster M.D. Medical Examiner.

Date signed May 18, 1945

G29002 — BALTIMORE CITY HEALTH DEPARTMENT — G29002

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 N. CALVERT ST?
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 25
(e) Length of stay in Baltimore (yrs., mos., or days) 37 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 N. CALVERT ST. (If rural give location)
(e) Citizen of foreign country? Russia (Yes or No) If yes, name country

3 (a) FULL NAME ANTONINA F. SELETZKY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife CONSTANTINE V. SELETZKY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 21. 1888

8. AGE: Years	Months	Days	If less than one day
57	2	27	hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation HOME DUTIES
11. Industry or business

FATHER
12. Name FRANZ CHUBINSKY
13. Birthplace RUSSIA

MOTHER
14. Maiden Name VERA BUTKEVICH
15. Birthplace RUSSIA

16 (a) Informant CONSTANTINE V. SELETZKY
(b) Address 3013 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 21. 1945 (month) (day) (year)
(c) Cemetery or crematory RUHID RIDGE
Location PIKESVILLE, BALTO. CO., MD.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 EUTAW PLACE

19 (a) MAY 19 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945; at 1. A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1942 to May 1945 and that I last saw her alive on May 14 1945

Immediate cause of death: Cardiac Failure — Duration 4 yrs.

Due to: Chronic Cardio-vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irene D. Gay
Address 1114 ST. PAUL ST. Date signed 5/19/45 M.

VS 150

G29003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29003 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 S Strickers St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Strickers St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luther L. Browning

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 12-1869

8. AGE: Years 76 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or Business

FATHER 12. Name Luther Browning

13. Birthplace Md

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Margaret Browning

(b) Address 113 S. Strickers St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Catt Cr B.M. Walters Sta

18 (a) Funeral director

(b) Address Pratt Strickers St

19 (a) MAY 19 1945 (Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945, at 1 P.M. WT

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1945 to May 17 1945 and that I last saw h. im alive on May 15 1945

Immediate cause of death: Cardiac Vascular disease — Duration: 2 mos.

Due to: Arteriosclerosis — Duration: unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Bauman and Lord M. D.

Address 2200 Garrison Blvd Date signed 5-19-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29004 Registered No. 93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 South Gilmore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 South Gilmore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael F. MADIGAN

3 (b) If veteran, name war None
3 (c) Social Security Account No. 705-07-6485

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Nellie Madigan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1878

8. AGE: Years	Months	Days	If less than one day
66	5	1	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Robt Madigan
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Millea
15. Birthplace Ireland

16 (a) Informant Mary M. Madigan
(b) Address 405 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21-1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balt & B. M. City

18 (a) Funeral director Pettit & Thicker
(b) Address

19 (a) MAY 19 1945 (Date filed by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/45 19 , at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Investigation Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 5/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G29005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Dunsan St-17
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 1363 Bender Ct (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Zimri Henry Kyle

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11. 7. 39

8. AGE: Years 5 | Months 6 | Days 11 | If less than one day ___ hr. ___ min.

9. Birthplace Galax Va (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Fred Kyle
13. Birthplace Va

MOTHER
14. Maiden Name Rosie Bryan
15. Birthplace Va

16 (a) Informant Fred Kyle
(b) Address 1363 Bender Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 / 19 / 45 (month) (day) (year)

(c) Cemetery or crematory
Location Galax Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 100 Bentley Ave.

19 (a) MAY 19 1945 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/ 1945, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5.8. 1945, to 5.18. 1945 and that I last saw him alive on 5.18. 1945.

Immediate cause of death: Duration
(a) Marasmus 5 days
Due to tuberculous meningitis 10 days
Due to pulmonary tuberculosis 3 wks?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.
Address 515 Mulberry St Date signed 5.18.45

X

G29006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. V 122a

G29006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Bessie E Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: wh.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1882

8. AGE: Years 62 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joshua M. Warner
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Julia Gist
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Julia Mullikin
(b) Address 2728 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 19 1945 (Date rec'd by registrar) (b) Huntington Williamson, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1945 to 5-17 1945, and that I last saw h. alive on 5-17 1945.

Immediate cause of death Aspiration, post. coronary insufficiency — Duration

Due to retroperitoneal infection — 2 hrs

Due to ruptured diverticula sigmoid colon — 2½ hrs

Other Conditions Chr. cholecystitis, diaphragmatic hernia — yrs.
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norton Benner M. D.
Address W. B. G. H. Date signed 5-17-45

123

G29007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G29007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3613 Woodbine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY I. ROSE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles L. Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1883

8. AGE: Years	Months	Days	If less than one day
61	10	3	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John E. Wyman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Hoffman
15. Birthplace Md.

16 (a) Informant Mr. John E. Wyman, Jr.
(b) Address 4232 Woodlea Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Com.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 19 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May 18, 1945, at 6:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/26/45 to 5/18/45, and that I last saw her alive on 5/3/45.

	Duration
Immediate cause of death Cerebral Hemorrhage	10 min.
Due to Cardio-vascular renal disease	15 yrs.
Due to	
Other Conditions Uremia Leucorrhagea (Include pregnancy within 3 months of death)	2 mos.

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Harper M. D.
Address 5201 Evergreen Rd. Date signed 5/19/45

VS 150

G29008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3010 Baker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3010 Baker St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME CATHERINE LILLIAN BOUDENARD

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Boudenard, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1863

8. AGE: Years 81 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Peter Salzig

13. Birthplace Germany

MOTHER

14. Maiden Name Barbara C. Meir

15. Birthplace Germany

16 (a) Informant Mrs. George Gaigley

(b) Address 3010 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) MAY 19 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1945, at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to May 18 1945 and that I last saw h[illegible] alive on May 9 1945.

Immediate cause of death: Chronic cardiac renal disease — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ernest W. Baker

Address 1735 Pops Ave Date signed 5/18/45

VS 150

628009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. 628009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Cleveland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IRENE J. SCHNECK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George B. Schneck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1891

8. AGE: Years	Months	Days	If less than one day
58 53	10	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Henry Becker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Kirschner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Donald Reier
(b) Address 722 Braeside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 19 1945 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944 to 5-17 1945 and that I last saw h[illegible] alive on 5-17 1945

Immediate cause of death	Duration
Acute Cardiac Failure	1d
Due to Cerebral Vascular Renal	
Due to Disease	6mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Carstens M. D.
Address 6 W. Chesapeake Ave. Date signed 5/19/45

VS 150

G23010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G23010 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 Harlem Ave.
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FLORENCE N. REESIDE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Oliver H. Reeside
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 10, 1899

8. AGE: Years	Months	Days	If less than one day
46	0	8	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William A. Oettinger
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Florence H. Davis
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Oliver H. Reeside
(b) Address: 2306 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 19 1945 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1945, at 12:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to May 18 1945 and that I last saw h[er] alive on May 17 45

Immediate cause of death: Carcinoma of breast — Duration

Due to (Met. to lungs & pelvic bones)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 31-1944

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L. Dodd, M.D.
Address 795 N. Fulton Ave. Date signed 5/18/45

VS 150

G29011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 E

Registered No. G29011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Guilford Ave. & 34th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: Guilford Ave. & 34th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: PAUL B. LUKE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Estelle Horney Luke
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1874

8. AGE: Years: 71 | Months: 0 | Days: 16 | If less than one day: hr. min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual Occupation: Real Estate Dept.
11. Industry or business: Safe Deposit & Trust Co.

FATHER
12. Name: Gratrott G. Luke
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Mary Wright
15. Birthplace: N. C.

16 (a) Informant: Miss Lillian P. Luke
(b) Address: Temple Court Apts.-Guilford Ave & 34th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem. Mausoleum
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 19 1945 (Date rec'd by registrar) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4th 1944 to May 17 1945 and that I last saw him alive on May 17 1945.

Immediate cause of death: Myocarditis with Cardiac asthma — Duration: 2 yrs
Due to: Myocardial insufficiency — 1 day
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J N Wilson
Address: 617 W. 40th St Date signed: 5/18/45

X

G28012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20E

Registered No. G28012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5509 Fernpark Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret E. Finke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife William Finke.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-3-1880

8. AGE: Years	Months	Days	If less than one day
65	4	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Paul Bowmers
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ida Watts
15. Birthplace Maryland.

16 (a) Informant Mr. Wm. Finke
(b) Address 5509 Fernpark Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) MAY 19 1945 (Date rec'd by registrar) (b) Huntingtown Williams Md. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1945, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1945 to 5/18 1945, and that I last saw her alive on 5/18 1945.

Immediate cause of death	Duration
Acute Circulatory Collapse	
Due to Luetic Cardio Vascular Disease	
Due to	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Capt Paul Smith, Jr. M.D.
Address St. Agnes Hosp Date signed 5/18/45

G29013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Church St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Church (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Hapis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years abt. 65 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name —
13. Birthplace Austria

MOTHER 14. Maiden Name —
15. Birthplace Austria

16 (a) Informant Mary Hapis
(b) Address 1628 Church St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location a.R. Co. Md

18 (a) Funeral director Wm. J. Galbraith
(b) Address 2007 Eastern Ave

19 (a) MAY 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17 1945, at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to 5/17 1945, and that I last saw him alive on 5/17 1945.

Immediate cause of death	Duration
hypertension cardio vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H.W. Kirsten M.D.
Address 302 Patapsco Ave Date signed 5/18/45

G23014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G23014 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Pk. apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leon P. Thayer

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of ~~husband~~ or wife Dorothy B Thayer
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1876

8. AGE: Years	Months	Days	If less than one day
68	8	12	..... hr. ..... min.

9. Birthplace Mass. (Town, county, and state)
10. Usual Occupation Vice President - retired
11. Industry or business International Harvester Co.

FATHER
12. Name Francis Thayer
13. Birthplace Mass.

MOTHER
14. Maiden Name Nancy Paine
15. Birthplace Rhode Island

16 (a) Informant Mr. William B. Tittsworth
(b) Address 2102 Chelsea Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) MAY 19 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1945, to 5/17 1945, and that I last saw h. alive on 5/17 1945.

Immediate cause of death Resp. Failure

Due to Bronchogenic Cancer & Cerebral Metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Cancer of Lung

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R C Lounger M.D.
Address Univ. Hosp. Date signed 5/21/45

X

Dr. Colley
5103 Harford Rd.

G23015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Gibbons Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 54
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Gibbons Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara B. Salter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Aquilla Y. Salter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1870

8. AGE: Years	Months	Days	If less than one day
74 75	4	29	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Maskell
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Chaulk
15. Birthplace ?

16 (a) Informant Mr. Joseph Salter
(b) Address 3205 Gibbons Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5605 Harford Road

19 (a) MAY 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945, to 5/17 1945, and that I last saw h[illegible] alive on 5/17 1945

Immediate cause of death	Duration
Carcinoma of stomach	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myers Colley M. D.
Address 5103 Harford Rd Date signed 5/19/45

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write correct age is especially important.

623016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937 C 550416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2538 Robb St.
(c) Hospital or institution:

9-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2538 Robb St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas or Gaetano La Paglia

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Tullia La Paglia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 13 1885

8. AGE: Years	Months	Days	If less than one day
59	5	5	hr. min.

9. Birthplace Calascibetta Italy
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER
12. Name Giuseppe La Paglia
13. Birthplace Italy

MOTHER
14. Maiden Name Giuseppina Coppola
15. Birthplace Italy

16 (a) Informant Tullia La Paglia (Wife)
(b) Address 2538 Robb St.

17 (a) Burial (b) Date thereof May 21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Weller Hoca
(b) Address 52 N. Morley St.

19 (a) (b) Registrar
(Date rec'd by registrar) MAY 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18, 1945 to May 18, 1945 and that I last saw him alive on May 17, 1945

Immediate cause of death	Duration
Myocarditis Chronic	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cunningham M. D.
Address 514 Druid Lane Date signed 5/18/45

X

G23017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. G23017

JO #93066

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 18 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 949 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Jones or Manuel Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1929

8. AGE: Years	Months	Days	If less than one day
15	11	15	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation school boy

11. Industry or business

FATHER
12. Name Ben Grisson
13. Birthplace New York

MOTHER
14. Maiden Name Christine McDougle
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 1945 (month) (day) (year)
(c) Cemetery or crematory Fayatteville
Location North Carolina

18 (a) Funeral director Mrs Katy R Williams
(b) Address 322 N Schroeder St.

19 (a) Filed by Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945 at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12, 1945 to May 16, 1945 and that I last saw h im alive on May 15, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis bilateral	6 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Fuller M. D.
Address Balto City Hosp Date signed 5/16/45

X

G29018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29018 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, ~~widowed~~ or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1871

8. AGE: Years 74 | Months 1 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Elizabeth Morris
(b) Address 1215 W. Lexington St

17 (a) Burial (b) Date thereof 5-22-'45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lincoln Memorial Cem
Location Washington, D.C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) (Date received by registrar) MAY 19 1945 (b) Washington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945 at 12 50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 17, 1945

G23019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G23019

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Cayuga Ave & Dukeland St.

(c) Hospital or institution: West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days): 15

(e) Length of stay in Baltimore (yrs., mos., or days): 6

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore -16 (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1905 Ellamont Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Henry A. Crouthamel

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife: Emily M. Crouthamel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29 1888

8. AGE: Years	Months	Days	If less than one day
56	6	19	hr. min.

9. Birthplace: Silverdale Pa. (Town, county, and state)

10. Usual Occupation: Garage owner

11. Industry or business:

FATHER

12. Name: Israel Crouthamel

13. Birthplace: Pa.

MOTHER

14. Maiden Name: Elizabeth Lutz

15. Birthplace: Pa.

16 (a) Informant: Mrs. Emily M. Crouthamel

(b) Address: 1905 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-27-45 (month) (day) (year)

(c) Cemetery or crematory: Forest Hill Town Baptist Church Cemetery

Location: Hilltown Pa.

18 (a) Funeral director: G. Howard Strong

(b) Address: 3207 W. North Ave

19 MAY 19 1945 (Month, day, year) Huntingdon Valley, Pa. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/18 1945, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1945 to 5/18 1945, and that I last saw him alive on 5/18 1945

Immediate cause of death	Duration
Subarachnoid Hemorrhage	days
Due to: HC VD.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Irving J. Taylor

Address: WBGN Date signed: 5/18/45 M.D.

G29020
TH. 93377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1126

Registered No. G29020

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 24-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3 (a) FULL NAME Anne Elizabeth Koppleman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Peter P.
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Dec 4th, 1910

8. AGE: Years	Months	Days	If less than one day
34	5	14	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Phillip Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Grace Wright
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 5/ 1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End of North Ave

18 (a) Funeral director John F. Henny Inc
(b) Address 718 Light St.

19 (Date rec'd by registrar) MAY 19 1945 Acting for Williams

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May 18th 1945 19 , at 1.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30th 45 to May 18th 45
and that I last saw her alive on May 18th 19 45

Immediate cause of death Pneumonia - Uremia — Duration

Due to Chronic Nephritis

Due to Acute Pancreatitis + Cholelithiasis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 5-1-45
Major findings of operation: Acute Pancreatitis
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Cutler
Address City Hospitals Date signed 5-18-45

VS 150

G29021
472684

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29021
CERTIFICATE OF DEATH 55a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Earle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise P Parks.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles A. Parks
6 (c) If alive, give age 36 years
7. Birth date of deceased (mo., day, yr.) 12-29-11
8. AGE: Years 33 Months 4 Days 20 If less than one day ....hr. ....min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name James Barrett
13. Birthplace Maryland

MOTHER
14. Maiden Name Lena Sullivan
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cemetery
Location Easton, Md.
18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108-20 North Ave, City
19 MAY 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 19 1945, at 1.03 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to May 19 1945, and that I last saw h[er] alive on May 19 1945

Immediate cause of death	Duration
Post-operative exhaustion	
Due to Removal of Carcinoma of left adrenal gland	
Due to	
Other Conditions Metastasis, left lung	

(Include pregnancy within 3 months of death)
Date of operation May 15, 1945
Major findings of operation: Carcinoma, left adrenal gland
of autopsy: same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ross L. McLean M. D.
Address Johns Hopkins Date signed 5-19-45

VS 150

X

G29022 ✓ G29022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 Linford
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ✓3
(e) Length of stay in Baltimore (yrs., mos., or days) 2mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Linford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME John R. Luckhams

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Naomi
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 18 185-1

8. AGE: Years 93 | Months 3 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Available
13. Birthplace Va

MOTHER 14. Maiden Name Mary Jones
15. Birthplace Va

16 (a) Informant Mrs Margaret Warren
(b) Address 2712 Linford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-45 (month) (day) (year)
(c) Cemetery or crematory Green Mt Baptist
Location Spring Grove Va

18 (a) Funeral director Evelyn A Fraley
(b) Address Fulton & Franklin Huntingtown, Md

19 MAY 19 1945 (Date rec'd by registrar) (b) Huntingtown, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945 to May 19 1945 and that I last saw him alive on 5-16 1945

Immediate cause of death: Acute myocarditis — Duration: 2 days
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 5-19-45

X

VS 150

G29023 — 2 29023 ✓ G29023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Sinai Hospital

(c) Hospital or institution: 1700 Block E. Monument St

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in Baltimore (yrs., mos., or days): 31 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1707 Sulgrave Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3 (a) FULL NAME: Dr. Joseph Jack Nurkin

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Goldie Nurkin

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 10, 1885

8. AGE: Years	Months	Days	If less than one day
59	10	8	hr. min.

9. Birthplace: Newark N.J. (Town, county, and state)

10. Usual Occupation: Physician

11. Industry or business:

FATHER — 12. Name	Solomon Nurkin
FATHER — 13. Birthplace	Russia
MOTHER — 14. Maiden Name	Rabyn ?
MOTHER — 15. Birthplace	Russia

16 (a) Informant: Mrs. Goldie Nurkin

(b) Address: 1707 Sulgrave Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 20/45 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Friendship

Location: 3600 E. Balto. st

18 (a) Funeral director: Sol Levinson & Bros

(b) Address: 1124-26 W. North ave

(c) Huntington Williams, M.D. Registrar

MAY 20 1945 (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945, at 10.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1945 to 5/18 1945, and that I last saw him alive on 5/18 1945.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to: Pulmonary Edema

Due to: Coronary Occlusion

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Philip H. Lerman M. D.

Address: Sinai Hospital Date signed: 5/18/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G23024

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Queensberry Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Queensberry Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Finz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation merchant

11. Industry or business

FATHER
12. Name Athenjaw
13. Birthplace Rugsia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Oscar Finz
(b) Address 5001 Queensberry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1431 E Balto St

19 (a) 5-20-1945 (Date received by registrar) (b) Arlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18-1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942 1945, to May 18 1945, and that I last saw h[illegible] alive on May 10 1945

Immediate cause of death: Pulmonary Edema — Duration 4 hr

Due to: — Duration

Due to Leukemia, Aleukemic Lymph — Duration 6 mo

Other Conditions Diabetes Mellitus — Duration 32 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Hespard M.D.
Address 209 W Lafayette Ave Date signed 5/19/45

VS 150

G29025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

G29025 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 3
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 N. Mumford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Mussorgh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Tailor (Self) Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hyman —
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude —
15. Birthplace Russia

16 (a) Informant Rose Mussorgh
(b) Address 36 N. Mumford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jos. Levinstine
(b) Address 1439 E. Balto. St

19 (Signed) Victor Williams, M.D. Registrar
(Date rec'd by registrar) MAY 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 19 45 at 1100 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 19 45 to 5/18 19 45, and that I last saw h. alive on 5/18 19 45.

Immediate cause of death

Duration

Due to Hemorrhage

Due to Ca. of Prostate

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca. of Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip A. Sherman M. D.

Address Date signed

24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G29026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

G29026 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St + Rutland Ave
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Chauncey Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERTHA WALLACE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation ~~Housewife~~

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant David Wallace
(b) Address 822 Chauncey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-45 (month) (day) (year)
(c) Cemetery or crematory Adath Israel Friendship
Location

18 (a) Funeral director Jos. Segura Inc
(b) Address 4439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1945, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1945 to 5-19 1945, and that I last saw her alive on 5-19 1945.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Hodgkin's disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Sinai Hospital Date signed 5-19-45

G29027 Eckhardt ✓ G29027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: Aged Indigent Women's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick H. Eckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Ida Eckler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 20 1869

8. AGE: Years 75 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Inmate

11. Industry or business: Home for Aged

FATHER
12. Name: Charles A. Eckhardt
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Augusta Staufner
15. Birthplace: Unknown

16 (a) Informant: Aged Home
(b) Address: 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)

(c) Cemetery or crematory: Lorraine Cem.
Location: Hood Avenue Maryland

18 (a) Funeral director: Fillmyer Cook, Inc.
(b) Address: 217 St. Paul Street

19 (a) MAY 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + ~~Autopsy~~ thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard A. Mulleis M.D. Medical Examiner.
Date signed May 19, 1945.

VS 151

A 41344 G29028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G29028 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Stutzman
3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Infant.
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-45

8. AGE: Years | Months | Days | If less than one day 5 hr. 45 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Arthur Stutzman
13. Birthplace Johnstown Pa.

MOTHER
14. Maiden Name Cathleen Ramey
15. Birthplace Marlinsburg W. Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/20/45 (month) (day) (year)
(c) Cemetery or crematory Greenhill Cem
Location Martinsburg W. Va.

18 (a) Funeral director William Bok Sons.
(b) Address 1217 St. Paul St.

19 (a) MAY 20 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1945 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:30 PM 5-19 1945 to 8:45 5-19-45 and that I last saw h[illegible] alive on 5-19 1945.

	Duration
Immediate cause of death Hemorrhagic Disease of the Newborn	5 hr 45 min
Due to x Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vitas A Nazar M. D.
Address Hopkins Hosp Date signed 5-[illegible]-45

G29029 G29029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 Homeland Ave
(c) Hospital or institution: St. Mary's Convent
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Homeland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Thomas (Isabelle O'Neill)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 11, 1906

8. AGE: Years	Months	Days	If less than one day
38	5	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Thomas O'Neill
13. Birthplace Baltimore

MOTHER
14. Maiden Name Loretta O'Neill Reilly
15. Birthplace Baltimore

16 (a) Informant Sister M. Prudens, Superior
(b) Address St. Mary's Convent

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Glen Arm

18 (a) Funeral director Geo. M. Fritsch Son
(b) Address 511 Harlem Ave Huntington Williams, M.D.

19 (a) MAY 20 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1- 1944, to 5-19- 1945, and that I last saw h[illegible] alive on 5-15- 1945.

Immediate cause of death

Due to Epilepsy - Grand Mal — Duration 0-5 Yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 5267 York Rd. Date signed 5-19-45

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G29030 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
General German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HELLWEG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1865.

8. AGE: Years	Months	Days	If less than one day
79	4	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name August Hellweg
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Greener
15. Birthplace Germany

16 (a) Informant Mr. J. George Walz, Sec't'y. General German Aged Peoples Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21/45. (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) MAY 20 1945 (Date received by registrar) (b) Hunting for Williams M.D. (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18/45. 19 6.30 P.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10/45 to May 18/45. and that I last saw him alive on May 15/45.

Immediate cause of death: Acute Cardiac Dilitation — Duration:
Due to: Chronic Cardiac Hypertrophy — Unknown.
Due to:
Other Conditions: Arterio-Sclerosis — Unknown.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Meade Clemens M. D.
Address 933 Hanover Date signed

X May 19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G28031 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Ramsay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Ramsay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Trott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Richard Trott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1882.

8. AGE: Years 62 | Months 6 | Days 21 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business Own home

FATHER
12. Name Charles Woolsey
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Dunn
15. Birthplace Ireland

16 (a) Informant Mrs. Alice Barehart
(b) Address 1406 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21/45. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Mitzke
(b) Address 4101 Edmondson Ave.

19 (a) 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16/45. 19.... at .... M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 45 to May 16 19 45.
and that I last saw h.. alive on May 16 19 45.

Immediate cause of death	Duration
Myocardial failure	1 day
Due to Carcinomatosis of Biliary System, &	1 year Approx.
Due to Metastases	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 W. Fayette St. Date signed 5/19/45

G29032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29032 X G29032 / 46E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33 ½ + Calvert

(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:

(a) State South Cal (b) County

(c) City or town Charleston, South Cal. (If outside city or town limits, write RURAL and give town)

(d) Street No. Rt. 5; Riverland Terrace (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Anna Limehouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr. I. T. Limehouse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-80

8. AGE: Years	Months	Days	If less than one day
64	7	24	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Dr. Robert Ilderton

13. Birthplace So. Carolina

MOTHER

14. Maiden Name Emma E. Cawley

15. Birthplace So. Carolina

16 (a) Informant Self

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/20/45 (month) (day) (year)

(c) Cemetery or crematory

Location CHARLESTON SC.

18 (a) Funeral director William J Tickner & Sons

(b) Address North & Pennsylvania Ave

19 (a) Thurlington Williams, M.D. (By whom filed) (b) Registrar

MAY 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1945, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1945 to 5-19 1945, and that I last saw her alive on 5-19 1945

Immediate cause of death	Duration
Pulmonary Embolism	
Due to	
Due to	
Other Conditions Carcinoma ? Sigmoid	

(Include pregnancy within 3 months of death)

Date of operation 5-3-45

Major findings of operation: Carcinoma of Sigmoid Colon

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.

Address U.M.H. Date signed 5-19-45

G29033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

G29033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl I Bond

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Etta Murphy

6 (c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1907

8. AGE: Years: 37 | Months: 5 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Lanaconing Md. (Town, county, and state)

10. Usual Occupation: Rigger

11. Industry or business: Beth. Steel Key Highway

FATHER
12. Name: John
13. Birthplace:

MOTHER
14. Maiden Name: Annie Sweetroute
15. Birthplace: Barton Md.

16 (a) Informant: Mrs. Carl Bond
(b) Address: 1731 N. Duncan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 22/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Hill
Location: Lanaconing Md.

18 (a) Funeral director: Wm. J. Schnitzler Sons
(b) Address: Madison & Pine Avenues

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MAY 26 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1945, at 2:45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from; natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Broken neck.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-19-45 at 2 P. M. Clinton
(b) Where did injury occur? PIER #3, ~~Baltimore~~
(c) Did injury occur at home, on farm, industrial place, in public place? INDUSTRIAL While at work? YES.
CAUGHT IN ROPE OF GRAIN ELEVATOR - PA. R. R.
(d) Means of injury

23. Signature: Howard J. Wilson M.D. Medical Examiner.
Date signed: May 26, 1945.

(004)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G29034
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Watson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Watson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RHODES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/1882

8. AGE: Years 63 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)

10. Usual Occupation LABOURER.

11. Industry or business

FATHER
12. Name UNKNOWN.
13. Birthplace MD

MOTHER
14. Maiden Name MARY ?
15. Birthplace MD

16 (a) Informant MRS. JULIA TROSS
(b) Address 1111 WATSON ST

17 (a) BURIAL (b) Date thereof S 21 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. BALTO NATIONAL
Location [redacted] D.

18 (a) Funeral director RAYNER SANDERS
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by Registrar) (b) Huntington Md. Registrar

MAY 20 1945
VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Arteriosclerosis

Arteriosclerotic gangrene 1 foot, left

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed May 17 1945

X

G25035 BALTIMORE CITY HEALTH DEPARTMENT G25035

CERTIFICATE OF DEATH 121

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 10
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Stewartstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Ruth Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/32

8. AGE: Years	Months	Days	If less than one day
12	7	11	hr. min.

9. Birthplace Stewartstown, Penna
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Ernest Allen
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Elizabeth McCaleb
15. Birthplace Shrewsbury Co Penna

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 1945 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location New York Rd

18 (a) Funeral director Edward Kelly
(b) Address 5200 Belair Rd

19 (a) 1945 (Date rec'd by registrar) (b) Certificate for Millicent Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945, at 5:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10/1945 to 5/20/1945, and that I last saw her alive on 5/20/1945.

Immediate cause of death	Duration
1	
Due to Generalized Peritonitis	
Due to Ruptured Appendix	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/10/45

Major findings of operation: Acute gangrenous perf. appendix -

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Scavone M. D.

Address St. Joseph's Hosp Date signed 5/20/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G29036

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Hackley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widowed

6 (b) Name of husband or wife Not Known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Sam'l Spearman Friend
(b) Address 1612 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 1945 (month) (day) (year)

(c) Cemetery or crematory U.S. National Cem'y
Location Balto. Md.

18 (a) Funeral director John M. Lyman
(b) Address 1709 Druid Hill Ave

19 MAY 21 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14-1945, at 12.05 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured 2nd & 3rd Cervical Vertebrae and dislocation of the 1st

Due to

Other Conditions Multiple fractures, contusions and bruises.
(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-13-1945 at 11.45 P.M. 14/2
(b) Where did injury occur? Penna. Ave. & Mosher St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Mercein M.D.
Medical Examiner.
Date signed 5-14-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29037 ✓ G29037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Madison Ave 2nd floor f.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 5 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William L. Ford
13. Birthplace Va

MOTHER 14. Maiden Name Hazel Scott
15. Birthplace Balto. Md

16 (a) Informant Hazel Ford
(b) Address 1712 Madison Ave

17 (a) Mt. Auburn (b) Date thereof 5-21-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave
Huntingdon Williams, M.D.
(Date received by Registrar) Registrar

MAY 21 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945 to May 19 1945, and that I last saw him alive on May 19 1945.

Immediate cause of death	Duration
Premature	
Due to	
7 months	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh H. Pemberton M.D.
Address 163 Druid Hill Date signed 5/24/45

× am

629038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 629038

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8 42
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boston Spraggins

3 (b) If veteran, name war —

3 (c) Social Security Account No. 205-10-9509

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beasie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-18-1878.

8. AGE: Years	Months	Days	If less than one day
66 65	7	—	hr. min.

9. Birthplace Charlotte, Va (Town, county and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Jacob Spraggins
13. Birthplace Va.

MOTHER
14. Maiden Name Julia ?
15. Birthplace Va.

16 (a) Informant Bessie W. Spraggins
(b) Address 539 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Cem
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave
(c) Filed MAY 21 1945 Huntington Williams (Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 6:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945, to May 15 1945, and that I last saw h alive on May 15 1945.

Immediate cause of death Carcinoma of Liver — Duration 6 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 757 Lenox Date signed 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G29039

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Forrest
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Forrest (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Holley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - - 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Watty
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Parker
15. Birthplace Md

16 (a) Informant Robert L. Hutchman
(b) Address 17 Calumet St. Newark N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Sam'l M. Chase Son
(b) Address 638 N. Gilmor St

19 (a) (Date rec'd by registrar) MAY 21 1945 (b) Huntington Hillsdale, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 27 1945 to May 18 1945, and that I last saw h[illegible] alive on May 18 1945.

	Duration
Immediate cause of death: Acute myocarditis	2 days
Due to: Chr. Nephritis	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Berry M. D.
Address 1420 E. Chase Date signed 5-19-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

Registered No. G25040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3131 Lauraview ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 Lauraview ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary K Dippold

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-4029

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8 76

8. AGE: Years	Months	Days	If less than one day
69	3		hr. min

9. Birthplace (Germany) Baltimore, Md. (Town, county and state)

10. Usual Occupation At home

11. Industry or business Seamstress - Home duties

FATHER
12. Name Martin Dippold
13. Birthplace Germany.

MOTHER
14. Maiden Name Mahgret Fleischman
15. Birthplace Germany.

16 (a) Informant Miss Anna Dippold
(b) Address 3131 Lauraview ave.

17 (a) Holy Cross (b) Date thereof 5-21-45
(Burial, cremation, or removal) (mo.) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location

18 (a) Funeral director Leonard J. Buck.
(b) Address 5305 Holland rd.

19 (a) MAY 21 1945 (Date received by Registrar) Huntington Williamstown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 18 1945 and that I last saw h[illegible] alive on May 18 1945.

Immediate cause of death: Cerebral hemorrhage — Duration: 7 days

Due to: Arteriosclerotic Cardio-Vascular disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H B Stevens M. D.
Address 2400 Erdman Date signed 5/21/45.

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

625041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625041 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Harlem Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matilda A. Gross

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife Thomas S. Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1877

8. AGE: Years	Months	Days	If less than one day
68 67	1	17	hr. min.

9. Birthplace Ann Arundle, Co., Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Levi Heavron
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Neal
15. Birthplace Md.

16 (a) Informant Matilda Gross
(b) Address 1502 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) (Date received by registrar) (b) MAY 21 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945 to May 17 1945 and that I last saw h alive on May 17 1945

Immediate cause of death Cerebral Hemorrhage — Duration 12 days

Due to Arteriosclerosis — ?

Due to Cerebral Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. H. Pickett M. D.
Address 1364 Lawdale Ave. Date signed 5-17-45

Huntington Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G25042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD OR BIND

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HENRY JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
42			....hr. ....min.

9. Birthplace Ayden, N. C.
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Henry Jenkins
13. Birthplace N.C.

MOTHER
14. Maiden Name Clara
15. Birthplace N.C.

16 (a) Informant Mary Jenkins
(b) Address 14 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location.....

18 (a) Funeral director James A. Stamps
(b) Address 1936 Eastfield St

19 (a) MAY 21 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945, at 8A. M

21. I certify that I took charge of the remains described above, held an Inquestion & autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Hyper tensive Cardio vascular disease

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 17 1945

G29043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G29043 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4907 Holder Avenue
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Volando Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA STURMFELSZ

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: George John Sturmfelsz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 14, 1868

8. AGE: Years	Months	Days	If less than one day
77	0	3	hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Lodenfeld
13. Birthplace: Germay

MOTHER
14. Maiden Name: Catherine Velte
15. Birthplace: Baltimore, Md.

16 (a) Informant: George J. Sturmfelsz, Jr.
(b) Address: 1208 Southview Road - 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-45 (month) (day) (year)
(c) Cemetery or crematory: Immanuel Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Hollins, M.D.

MAY 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1945, at 1.55 P.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945, to May 17 1945 that I last saw her alive on May 17 1945.

Immediate cause of death: Hypertensive cardiovascular renal disease. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm D Schmitz

Address 701 N. Fenwood Ave. Date signed V 7/45

X

35-0691
G29044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G29044
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middleborough
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 16 Box 207
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No. 187-07-6258

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Verna Hartman

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 1-28-00

8. AGE: Years 45 | Months 3 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business G. L. Martin

FATHER
12. Name Emberter Hartman
13. Birthplace Pa.

MOTHER
14. Maiden Name Ella Wassler
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5 24 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Emmans Penna

18 (a) Funeral director Samuel Bradenbaugh
(b) Address 1407 Eastern Ave Rd. Essex

19 (a) MAY 21 1945 Huntington Williams M.D.
(Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 20 - 1945, at 4 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7-1945 to 5-20-1945, and that I last saw him alive on 5-20-1945

Immediate cause of death respiratory failure — Duration

Due to cerebral hemorrhage

Due to hypertensive cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Graham A. Venner M. D.
Address Johns Hopkins Hosp 5/20

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G29045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G29045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 N. Potomac Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HULDAH B. WALDRON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1860

8. AGE: Years	Months	Days	If less than one day
84	8	28	hr. min.

9. Birthplace Lafayette County, Wis.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles Bird
13. Birthplace Canada

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Fred Berbig
(b) Address 1220 N. Potomac Street

17 (a) Removal (b) Date thereof May 21, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Darlington, Wisconsin

18 (a) Funeral director William Cook, Inc.
(b) Address [illegible] Washington Boulevard

19 (a) MAY 21 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945, to May 20 1945, and that I last saw her alive on May 20 1945.

Immediate cause of death	Duration
Acute dilitation of heart	3 days
Due to Arteriosclerosis	??
Due to	
Other Conditions Auto-intestional intoxication (Include pregnancy within 3 months of death)	about 5 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S. Tublett M. D.
Address 2220 Garrison Blvd. Date signed May 21/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23046

CWK-93459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G23046

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 620 W. Saratoga Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Mary Sykes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1909

8. AGE:	Years	Months	Days	If less than one day
	35	9	21	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Lonnie Taylor

13. Birthplace North Carolina

MOTHER

14. Maiden Name Florrie Parkins

15. Birthplace Virginia

16 (a) Informant Records, Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof May 22, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Suffolk
Location Virginia

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (b) Registrar
(Date received by registrar) MAY 21 1945

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 18-45 1945, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945, to May 18 1945, and that I last saw h. er alive on May 18 1945.

	Duration
Immediate cause of death: Pneumonia	1 day
Due to:	
Due to:	
Other Conditions: Carcinoma Cervix with generalized metastasis	5 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Houck E. Dalton M. D.

Address Balt. City Hosp. Date signed 5/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G28047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G28047 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd Charles Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Blanche K. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Calvary Co. Md.. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name George Johnson.
13. Birthplace Calvary Co. Md.,

MOTHER 14. Maiden Name Martha ?
15. Birthplace Md..

16 (a) Informant Blanche Kelly Johnson.
(b) Address 932 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Local registrar) (b) Huntington Whitelow, Registrar

MAY 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 1.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1945 to 5/16 1945, and that I last saw h alive on 5/16 1945.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Woodland
Address Provident Hospital Date signed 5/16/45

X

G29048

BALTIMORE CITY HEALTH DEPARTMENT ✓ G29048

CERTIFICATE OF DEATH 108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5209 Elmer Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5209 Elmer Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John H Ford ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-4352

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: late Annie M.

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Oct 27th 1870

8. AGE: Years 74 | Months 6 | Days 22 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business (Private.)

FATHER
12. Name John Ford
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Connelly
15. Birthplace Ireland

16 (a) Informant Mrs Geo W. Cavanaugh
(b) Address 2639 Lauretta Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/22/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) Filed by registrar May 22 1945 Hunting Town Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1945 to May 19 1945; and that I last saw him alive on May 19 1945

Immediate cause of death	Duration
Myocarditis	2 Dys
Due to Edema of Meninges	2 Dys
Due to Prostatitis (op)	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Charles J Wells M.D.
Address 5176 Park Heights Ave Date signed May 20, 45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29049

TN. 93647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G29049 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Carlton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25th, 1900

8. AGE: Years 44 | Months 4 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elijah Brown (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Saphania ? (D
15. Birthplace Delaware

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill-AA Co.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St Huntington Williams, Inc

19 MAY 21 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th, 1945 at 2.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16th 1945 to May 16 1945 and that I last saw h im alive on May 16th 1945

	Duration
Immediate cause of death: Pulmonary hemorrhage	20 min
Due to: Pulmonary tuberculosis	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 5/21/45

VS 150

SUBJECT TO APPROVAL OF MEDICAL EXAMINER for H. B. Mitchell Leonard D. Mullen, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G29050 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 E. Preston Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry F. Trentler

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-5723

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	m

6 (b) Name of husband or wife Anna Mastrian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19-1892

8. AGE: Years	Months	Days	If less than one day
52	7	29	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER
12. Name George F. Trentler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Hart
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs Walter M. Blackburn
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belgin Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 901 Allendale Ave

19 (a) MAY 21 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945, to May 18 1945, and that I last saw h[illegible] alive on May 18 1945.

Immediate cause of death	Duration
Metastatic Carcinoma of Neck.	3
due to Generalized Metastasis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klemm M.D.

Address 2623 E. Monument Date signed 5/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G29051 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 E Oliver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 E. Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Reilly ✓

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph W. Reilly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12. 1865

8. AGE: Years: 80 | Months: 0 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: House Work

11. Industry or business

FATHER
12. Name: James McMahon
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Callahan
15. Birthplace: Ireland

16 (a) Informant: Mr. John Reilly (Son)
(b) Address: 1718 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 22/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: 4300 Old Frederick Rd

18 (a) Funeral director: Edward W. Conklin & Son
(b) Address: 924 Eager St.

19 (Date rec'd by registrar) MAY 21 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945 at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13, 1945 to 5-19, 1945 and that I last saw h[illegible] alive on 5-18 1945

Immediate cause of death: pulmonary edema — Duration: 1 hour

Due to: Myocardosis with dropsy — Duration: unkn

Due to: Gen. arteriosclerosis — Duration: unkn

Other Conditions: Right terminal lobar pneumonia — Duration: 5 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Myron D. Boyko M. D.
Address: 1626 N. Carolina St. Date signed: 5-19-1945

VS 150

90B

G29052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G29052

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution: L. Monument & Wolfe

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1100 Wilcox St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William J. Albracht

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife (nee McQuillan) Margaret B Albracht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 6, 1879

8. AGE: Years 65 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace New York City, N.Y. (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business American Taylor Co.

FATHER 12. Name George Albrecht

13. Birthplace N.Y.

MOTHER 14. Maiden Name Not Known

15. Birthplace " "

16 (a) Informant Mrs. Hilda Hilland

(b) Address 1100 Wilcox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24/45 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral Cemetery

Location 4300 Old Frederick Rd.

18 (a) Funeral director Edwin W. Conklin & Son

(b) Address 924 E. Eager St.

19 (a) MAY 21 1945 Huntington Williams, M.D.

Filed Rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1945, to 5/20 1945, and that I last saw h[illegible] alive on 6/20 1945.

Immediate cause of death	Duration
Pneumonia	
Due to Lobar pneumonia	
Due to general debilitation resulting from Ca of oesophagus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of oesophagus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed 5/21/45

X

VS 160

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G29053

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 N. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Georgianna Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	M

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Willie Saunderson

13. Birthplace Va

MOTHER 14. Maiden Name —

15. Birthplace

16 (a) Informant Walter Miller

(b) Address 1628 N. Gilmor St

17 (a) Burial (b) Date thereof 5/23/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Md

18 (a) Funeral director Geo. A. Kelly

(b) Address 1303 Pennsylvania Ave

19 (a) MAY 21 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1945 at 6 10 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure.

Due to

Other Conditions Chronic Valvulitis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

(e) Signature Howard J. Uhrich M.D.
Medical Examiner.

Date signed 5-19-45

G29054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G29054 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Lorman St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Lorman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Agnes Blake

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fem.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife George Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/1889

8. AGE: Years 55 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Samuel Penn
13. Birthplace Md

MOTHER
14. Maiden Name Bessie —
15. Birthplace Md

16 (a) Informant Beatrice Ingram
(b) Address 1702 Lorman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/45 (Month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Ged. L. Kefauver
(b) Address 1303 Pressman

19 (a) MAY 21 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945; at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 19 1945, and that I last saw h alive on 5-19 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day.
Due to Hypertensive Cardiac Disease	about 1 year.
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature C. R. Pilforth
Address 536 W. Lanvale St Date signed 5-21-45 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

GORDON

G29055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G29055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(c) Street No. 2312 Aiken St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L. Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25th 1878

8. AGE: Years	Months	Days	If less than one day
67	-	25	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Thomas L. Gordon
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Zebelein
15. Birthplace Md

16 (a) Informant Mrs Lehance
(b) Address 18 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23rd 1946 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltoleum
Location E North Ave, Est

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N Patterson Park Ave

19 (a) MY 21 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1946, at 12:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereof and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Leibinath M.D.
Medical Examiner.
Date signed 6/5/46

G29056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 97

G29056

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SINIA HOSP.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 YEAR

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. EDGEWATER APT.276 ESSEX
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLAUIDA IVES

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: W.R.IVES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): AUG.27 1895

8. AGE: Years 49 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace: GEORGIA
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: JOHN TAYLOR
13. Birthplace: GEORGIA

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GEORGIA

16 (a) Informant: W.R.IVES (HUSBAND)
(b) Address: 276 EDGEWATER APTS.ESSEX

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 25/45 (month) (day) (year)
(c) Cemetery or crematory: WEST NOBLE CEM.
Location: WEST NOBLE ST.ANNISTON ALA.

18 (a) Funeral director: Tilly and Tiller INC
Address: 403 [illegible] Williams, MD

MAY 21 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1945, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9 1945 to 5/20 1945, and that I last saw her alive on 5/20 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Myocardial Failure	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/19/45
Major findings of operation: Gangrene of Extremity
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip A. Lerman M. D.
Address Sinia Hospital Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29057
CWK-93687

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G29057

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 62- 5- 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2657 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William O. Wheary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Christina(D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15-1882

8. AGE: Years	Months	Days	If less than one day
62	5	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles O. Wheary (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Catharine Robinson (D)
15. Birthplace ?

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director Uelmi Funeral Home
(b) Address 2008 Orleans St

19 (a) MAY 21 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945 to May 19 1945, and that I last saw him alive on May 19 1945

Immediate cause of death Cerebral hemorrhage

Duration 24 hrs

Due to Cerebral arteriosclerosis & hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 5-20-45

X

G23058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √54 B

Registered No. G23058

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd St.

(c) Hospital or institution: Union Memorial Hospital 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 2.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1314 East 33rd St.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME EDWARD GEORGE NORWOOD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Mrs Ann Norwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1887

8. AGE: Years 65 | Months 2 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name ? Norwood

13. Birthplace Maryland.

MOTHER 14. Maiden Name Minnie Brecht

15. Birthplace Maryland

16 (a) Informant wife

(b) Address 1314 East 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 1945 (month) (day) (year)

(c) Cemetery or crematory Maryland Mem

Location Balto Co Md

18 (a) Funeral director Hillen Funeral Home

(b) Address 2008 Orleans St

19 (a) ..... (Date rec'd by Registrar) (b) Huntington Registered Nurse 332 E University Pkwy

MAY 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945 to May 19 1945 and that I last saw him alive on May 19 1945.

Immediate cause of death Cardiorespiratory Failure — Duration Instant

Due to Brain tumor, st. — ?

Due to

Other Conditions — over

(Include pregnancy within 3 months of death)

Date of operation Craniotomy May 12, 1945

Major findings of operation Rt sided tumor of brain

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury

23. Signature Geo. Lee Thompson Jr. M. D.

Date signed 5/23/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

39c

629059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3425 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura Allison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James T Allison
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9 1877.

8. AGE: Years 67 | Months 6 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Cyrus Orwig
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Duff
15. Birthplace Maryland

16 (a) Informant James T Allison
(b) Address 3425 Falls Rd City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Rhinowitz & Donovan
(b) Address 615-17 Eastern Ave

19 (a) MAY 21 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1945, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1945 to 5-19 1945, and that I last saw h[illegible] alive on 5-19 1945.

Immediate cause of death	Duration
C-R failure	
Due to Fever Unknown Origin	3 weeks
Due to	
SUPPLEMENTARY REPORT:	
Other Conditions ROCKY MOUNTAIN SPOTTED FEVER	
(Include pregnancy within 3 months of death)	

Date of operation (Over)
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Naughton Jr. M. D.
Address 332 E. University Pkwy. Date signed 5/19/45

VS 150

Huntington Williams M.D. Attending Staff

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29060 G29030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2656 Lauretta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. SANTMYER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle Santmyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 7, 1896

8. AGE: Years	Months	Days	If less than one day
49	1	11	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Sergeant
11. Industry or business: Detective Bureau Balto. City

FATHER
12. Name: James R. Santmyer
13. Birthplace: Va.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Myrtle Santmyer
(b) Address: 2656 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) MAY 21 1945 (Date rec'd by registrar) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18 1945, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1945 to 5-18 1945, and that I last saw him alive on 5-18 1945.

Immediate cause of death: Hepato-Renal failure — Duration

Due to: Diabetic coma and acidosis.

Due to: Diabetes Mellitus + Carbuncle of Scalp

Other Conditions: Uremia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Jerome R. Darkin, M.D.
Address: Sinai Hospital Date signed 5/18/45

G29051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G29051

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 9 or 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 E. 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lelia Maude Kelley

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife William Kelley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1881

8. AGE: Years 63 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Centerville, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William T. Elliott
13. Birthplace Centerville, Md.

MOTHER
14. Maiden Name Laura Brown
15. Birthplace Centerville, Md.

16 (a) Informant Mrs. Chris Witteman
(b) Address 907 E. 37th St.

17 (a) Burial (b) Date thereof 5/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 31 1945 (b) Huntington Williams Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1945 to 5/20 1945, and that I last saw her alive on 5/20 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to: Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M.D.
Address University Hosp. Date signed 5/20/45

VS 150

1x

G23062 G23062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 838

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3725 W. Garrison Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3725 W. Garrison Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIAN ESTELLA PRICE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel J. Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1892

8. AGE: Years	Months	Days	If less than one day
53	3	10	hr. min.

9. Birthplace Whitehall, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name David Price Akehurst

13. Birthplace Balto. Co., Md.

MOTHER

14. Maiden Name Ida Gertrude Tipton

15. Birthplace Md.

16 (a) Informant Mr. Samuel J. Price

(b) Address 3725 W. Garrison Ave.

17 (a) Burial (b) Date thereof 5/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olive

Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) (b)
(Date received by registrar) Livingston Williams Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 19, 1945, at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to May 19 1945 and that I last saw her alive on May 19 1945

Immediate cause of death	Duration
Terminal Bronchopneumonia	3 days
Due to Congestive Heart Failure	2 mos.
Due to Left Hemiplegia	2 wks.
Other Conditions Cerebral embolism - right middle cerebral artery	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Millard E. Lowman M. D.

Address 5813 Park Heights Ave Date signed 5-21-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629063

JL - 90541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

629063

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 18

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2644 Garrett Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha P. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1854

8. AGE: Years 91 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md.
(Town, County, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name Jno. W. Russell

13. Birthplace Balto., Co.,

MOTHER

14. Maiden Name Maria Coe

15. Birthplace Baltimore Co.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5-21-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Baltimore

18 (a) Funeral director Leonard J. Luck

(b) Address 5[illegible] Hayfield Road, Baltimore, Md.

19 (a) MAY 21 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 45 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 19 44 to May 18 19 45 and that I last saw her alive on May 18 19 45

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Sen. Arteriosclerosis
Cerebral Thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Woodward M. D.

Address Baltimore City Hospitals Date signed 5-20-45

VS 150

G29064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29064
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JANIE Ida .. COUSINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Johns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	23	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Solomon Mayo
13. Birthplace Va.

MOTHER
14. Maiden Name Ellen Cooper
15. Birthplace Va.

16 (a) Informant Enell Palmer
(b) Address 1207 E. Madison St.

17 (a) Removal (b) Date thereof May 23 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Irwin Virginia

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945 at 5 00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature H. C. Jubinville M.D.
Medical Examiner.
Date signed May 21 1945

G29065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

G29065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 E. Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 E. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. James

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Martha Jones

(b) Address 105 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/20 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave

19 (a) MAY 21 1920 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 20 - 9 ..., at ... M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Worsam M.D. Medical Examiner.

Date signed May 20, 1920.

VS 151

G29066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G29066

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Thomas Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Julia A. Palmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1. 1883

8. AGE: Years	Months	Days	If less than one day
61	7	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Farmhand

11. Industry or business

FATHER
12. Name David Palmer
13. Birthplace Pa.

MOTHER
14. Maiden Name Lydia Minnick
15. Birthplace Md

16 (a) Informant Julia B. Palmer
(b) Address Rose Hill, Pikesville, Md.

17 (a) Burial (b) Date thereof 5/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Bolair Road

19 (a) MAY 22 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945, to May 20 1945, and that I last saw him alive on May 20 1945.

Immediate cause of death	Duration
Terminal Pneumonia	
Due to	
Due to Miliary	
Other Conditions Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: Miliary Tuberculosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Address Md. Genl. Hospital Date signed 5/23/45

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

G29067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G29067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 WILLIAM ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1513 WILLIAM ST~~ 125 N OSTEND ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JULIA. ROLF

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 16-1945

8. AGE: Years | Months 4 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name GEORGE ROLF
13. Birthplace BALTO MD.

MOTHER
14. Maiden Name ANNA BRAUN
15. Birthplace BALTO MD

16 (a) Informant ANNA ROLF (MOTHER)
(b) Address 1513 WILLIAM ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-22-45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM
Location BALTO MD

18 (a) Funeral director Bernard C. Hank
(b) Address 121 E WEST ST

19 (a) (Date received by Local Registrar) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 20 1945, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1945 to 5-20 1945 and that I last saw h[illegible] alive on 5-1 1945.

	Duration
Immediate cause of death Hydrocephalus Congenital	since birth
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ballard M. D.
Address 207 E. Fort Ave. Date signed 5-21-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29068 — BALTIMORE CITY HEALTH DEPARTMENT — G29068

AB-93139

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1mos-4days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5005 Pratt Street. over 505 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Daniel Simering

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-8474

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife: Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 10-1892

8. AGE: Years 52 | Months 5 | Days 10 | If less than one day ____hr. ____min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Absalon Simering
13. Birthplace: Md.

MOTHER
14. Maiden Name: Jenny Schneider
15. Birthplace: Penna.

16 (a) Informant: Baltimore City Hospitals (Records)
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem
Location: Balto Md

18 (a) Funeral director: Bernard C. Hasler
(b) Address: 121 E. West St

19 (a) (Date received by registrar) MAY 22 1945 (b) Attesting for Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20- 1945, at 1.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1945, to 5-20- 1945, and that I last saw h im alive on 5-20- 1945

Immediate cause of death: Pulmonary tuberculosis — Duration: 3 yrs.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harold Dillon M. D.
Address: Baltimore City Hosp. Date signed 5/21/45

VS 190

G29069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G29069 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2008 Wilhelm St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Sigwart

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-7265

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	W	Married

6 (b) Name of ~~husband or~~ wife Sophia Sigwart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26th 1874

8. AGE: Years	Months	Days	If less than one day
70	9	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Grass Cutter
11. Industry or business Loudon Park Cemetery

FATHER
12. Name Max Sigwart
13. Birthplace Sweden

MOTHER
14. Maiden Name Lena (Unknown)
15. Birthplace Md.

16 (a) Informant Henry Young
(b) Address 2008 Wilhelm St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAY 22 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1945 at M

21. I certify that I took charge of the remains described above, held an Inspection ~~Autopsy~~ and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchogenic Carcinoma of Lungs
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Tubinaki M.D. Medical Examiner.
Date signed 5/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29070 ✓ G29070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 E. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 E. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abaham Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Feare -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Driver

11. Industry or business

FATHER
12. Name Harris -
13. Birthplace Russia

MOTHER
14. Maiden Name Myllre -
15. Birthplace Russia

16 (a) Informant Lee Fine
(b) Address 3911 Harrington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-45 (month) (day) (year)
(c) Cemetery or crematory Russdale
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1436 E. Balto St

19 (a) (Date received by registrar) MAY 22 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21-45 19..., at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 19... to 5/21 19...; and that I last saw h.. alive on 5/20 19...

Immediate cause of death: Acute Cardiac dilatation — Duration

Due to:

Due to: acute Coronary upset, Infarct.

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. C. Feldman M.D.
Address 1440 E Biddle Date signed 5/24/45

X

G29071 Philias Mason

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29071 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Philias Mason

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/1933

8. AGE: Years 12 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Marlow Mason
13. Birthplace Va.

MOTHER
14. Maiden Name Sabra Mason
15. Birthplace Va.

16 (a) Informant Sabra Mason (M)
(b) Address 837 Edmonson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director Chas H. Orrison
(b) Address 512 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAY 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1945 at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1945 to 5/21 1945 and that I last saw h[illegible] alive on 5/21 1945.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions Terrible Meningitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Sprague Jr. M.D.
Address Univ. Hosp Date signed 5/22/45

Huntington Williams, M.D.

629072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. 629072

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Adkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-98

8. AGE: Years	Months	Days	If less than one day
47	-	4	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Adam Adkins
13. Birthplace N.C.

MOTHER
14. Maiden Name Melvicie Edwards
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 22 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1945 to 5-14 1945; and that I last saw him alive on 5-14 1945.

Immediate cause of death	Duration
Metastasis	6 mos
tuberculosis, acute	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen R Leymaster M.D.
Address J. H. Hospital Date signed 5/17/45

2711

VS 150

G29073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G29073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 W. Preston St
(c) Hospital or institution: ✓ 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 W. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant 2 Margaret Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Raphael

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 5/20/45

8. AGE: Years | Months | Days | If less than one day hr. ✓ min.

9. Birthplace 520 W. Preston St (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raphael
13. Birthplace "

MOTHER
14. Maiden Name Margaret Brown
15. Birthplace "

16 (a) Informant Margaret Douglas
(b) Address 520 W. Preston St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 22 1945

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 22 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/45 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 19 5/20/45 and that I last saw him alive on 5/20/45

Immediate cause of death Pt unconscious & paralyzed Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Ellis M. D.

Address 22 W. Madison Date signed 5/22/45

VS 150

2710

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-29074 G-29074

BALTIMORE CITY HEALTH DEPARTMENT ✓ 159 Registered No. E-4864

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hosp.
(c) Hospital or institution: North Broadway
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Elliton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/19/45

8. AGE: Years | Months | Days | If less than one day 4 hr. min.

9. Birthplace Church Home Hosp (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Harvey White
13. Birthplace Tennessee

MOTHER 14. Maiden Name Dorothy Titcomb
15. Birthplace New Jersey

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19/45 at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 1945 to 5 1945 and that I last saw h alive on 5 1945

Immediate cause of death respiratory failure — Duration

Due to premature infant

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Phyllis B. Ingram M. D.
Address Date signed

2712 X

G29075

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G29075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland, 17
(b) Street address Lafayette + Johns St.
(c) Hospital or institution:
Hospital for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.-7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Marmon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brakeman, Lydia Flower

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles S. Brakeman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1883

8. AGE: Years 61 | Months 8 | Days 16 | If less than one day: hr. min.

9. Birthplace: Cochranton, Pa.
(Town, county, and state)

10. Usual Occupation: --

11. Industry or business

FATHER
12. Name: Chauncey M. Flower
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Laura Sargent
15. Birthplace: Pa.

16 (a) Informant: Mr. Richard F. Brakeman
(b) Address: 3602 Marmon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/45 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Cem.
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAY 22 1945

(b) Huntington Williams, M.D.
(Deputy Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1945, 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1945, to 5-20 1945, and that I last saw h[illegible] alive on 5-20 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 20 min.

Due to:

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation 5-12-45

Major findings of operation: Intraligam Fibromyomata

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: T. Edgie Russell M. D.

Address: Hosp. for Women of Md. Date signed 5-20-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G29076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Waynesboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Philadelphia Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Rossi

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Catherine Rossi
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1870

8. AGE: Years	Months	Days	If less than one day
74	8 9	25 24	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Dominic Rossi
13. Birthplace Italy

MOTHER
14. Maiden Name Philomena Renzi
15. Birthplace Italy

16 (a) Informant Miss Amelia Rossi
(b) Address Waynesboro, Penna

17 (a) Burial (b) Date thereof May 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Andrews
Location Waynesboro Pa.

18 (a) Funeral director Walter Y. Grove
(b) Address 27 E. Church St., Waynesboro Pa.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 22 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1945, at 5-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1945, to 5-22 1945 and that I last saw him alive on 5-21 1945.

Immediate cause of death	Duration
Peritonitis	7-8 days
Due to Breakdown D ileo-colic anastomosis	7-8 days
Due to Carcinoma D Cecum	
Other Conditions Cardiac Enlargement & Mitral Insufficiency	7 years

(Include pregnancy within 3 months of death)

Date of operation 5-12-45

Major findings of operation: Inoperable Ca D Cecum

of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin N. Davis M. D.
Address Church Home Date signed 5-23-45

X

G29077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29077

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 4409 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Brenize

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7912

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice Ellen Brenize

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1880

8. AGE: Years: 64 | Months: 10 | Days: 10 | If less than one day: hr. min.

9. Birthplace Mt Washington, Maryland (Town, county, and state)

10. Usual Occupation Telegrapher

11. Industry or business Pennsylvania Railroad

FATHER
12. Name Joseph Brenize
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Jennie Hannah Bailey
15. Birthplace Maryland

16 (a) Informant Mrs. Alice Ellen Brenize
(b) Address 4409 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23-1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3600 Falls Road

19 (a) MAY 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Lucas M.D. Medical Examiner.
Date signed May 23 1945.

G29078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G29078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 - 0 - 4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 E Balto. St. (Rooms)
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME David H. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Burial (b) Date thereof 5/22/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director A. Lee Alder
(b) Address 4644 York Rd.

19 (a) (Date rec'd by Registrar) MAY 23 1945 Huntington Williams, M.D. Registrar

VS 15f

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4- 1945 at 11:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to.....

Other Conditions Aortic Regurgitation, Essen. H. Brain & Lungs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Alder M.D.
Medical Examiner.
Date signed 5-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RIGHTS RESERVED - DO NOT FOLD OR BIND

G29079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G29079

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Bond St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Tom Watson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-23-97

8. AGE: Years	Months	Days	If less than one day
48	2	26	..... hr. ..... min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Laundry Worker
11. Industry or business.....

FATHER
12. Name Charles Watson
13. Birthplace S.C.

MOTHER
14. Maiden Name Annie Robinson
15. Birthplace S.C.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 45 (month) (day) (year)
(c) Cemetery or crematory.....
Location Charleston S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradley Ave.

19 (a) 5-21-1945 Huntington Williams, M.D. (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1945 to 5-19 1945, and that I last saw him alive on 5-19 1945.

	Duration
Immediate cause of death Massive intra abdominal hemorrhage	1 hr.
Due to Carcinoma of stomach involving liver & duodenum	11 mo.
Due to.....	
Other Conditions Subtotal gastrectomy - Post-op. Jejunal ulcer	

(Include pregnancy within 3 months of death) Postmortem

Date of operation Feb. 26 1945

Major findings of operation: Gall bladder. Carcinoma of stomach & metastasis to liver, duodenum.

Findings of autopsy.....

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature W. W. Forman

Address Johns Hopkins Date signed May 23 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

G29080 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument St
(c) Hospital or institution:
Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Lansdowne Broadway & Monument St
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Union Hospital
2307 Hammonds Ferry Rd (If rural give location)
(e) Citizen of foreign country? U. S. a. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Blamberg BLAMberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			6 hr. min.

9. Birthplace Union Hosp Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clyde Blamberg
13. Birthplace 2307 Balto Md

MOTHER
14. Maiden Name Clara Isabel Simmons
15. Birthplace Mt Airy Md

16 (a) Informant Clara Blamberg
(b) Address 2307 Hammonds Ferry Rd Lansdowne Md

17 (a) Burial (b) Date thereof 5-22-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location

18 (a) Funeral director L. J. Rusch

(b) Address 5305 Harford Rd

19 (a) (Date received by local registrar) MAY 22 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 19 45 to 5/20 19 45 and that I last saw her alive on 5/20 19 45

Immediate cause of death Respiratory failure — Duration

Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Pierce M. D.

Address 4 Greenwood Pl Date signed 5/21/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G29081 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River, 20 (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Stevens Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			4 hr. 15 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carrol Davis
13. Birthplace 204 Stevens Rd

MOTHER
14. Maiden Name Mary Helena J. Davis
15. Birthplace Welch W. Va

16 (a) Informant Hospital Records
(b) Address

17 (a) Burris (Burial, cremation, or removal) (b) Date thereof 5-22-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Rusch
(b) Address 5805 Harford Rd.

19 (a) 1945 (b) Huntington Williams
MAY 22 1945 Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 12 1945, and that I last saw him alive on May 12 1945.

Immediate cause of death CARDIO RESPIRATORY COLLAPSE — Duration

Due to PREMATURITY

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Joseph's Hosp. Date signed 5-19-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G29082
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 558 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Spriggs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female
5 Color or race: Negro
6 (a) Single, married, widowed, or divorced: Baby
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 13, 1944
8. AGE: Years | Months: 8 | Days: 7 | If less than one day: hr. min.
9. Birthplace Maryland (City, town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name John J. Spriggs
13. Birthplace Md.

MOTHER
14. Maiden Name Rosetta Griffen
15. Birthplace Md.

16 (a) Informant Rosetta Spriggs
(b) Address 558 Oxford St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Adolphus Halstead
(b) Address 718 Druid Hill Ave.
19 (a) MAY 22 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945, at 5:55 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1945 to 5/20 1945, and that I last saw her alive on 5/20 1945.
Immediate cause of death Tuberculous meningitis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. R. Campbell
Address Provident Hospital Date signed 5/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29083

BALTIMORE CITY HEALTH DEPARTMENT ✓ G29083 Registered No.

CERTIFICATE OF DEATH 14

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp. 11 B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Linden Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Rogers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Col	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1944

8. AGE: Years	Months	Days	If less than one day
1	4	19	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child.

11. Industry or business —

FATHER
12. Name Thomas Rogers
13. Birthplace Elliott City, Md.

MOTHER
14. Maiden Name Catherine Naylor
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 827 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) MAY 22 1945 (b) Huntington Williams, M.D.

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1945 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1945, to 5/21 1945, and that I last saw her alive on 5/21 1945

Immediate cause of death Resp. fail

Duration
4wk

Due to Meningitis

Due to tubercle bacillus

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 5-21

X

Spec.–7-17-26—A Co.—200 Bks.

G29084

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29084

CERTIFICATE OF DEATH

61

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2853 W. Garrison Ave St., 27-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Palmer

(a) RESIDENCE NO. 2853 W. Garrison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida E. Palmer

6 DATE OF BIRTH (month, day, and year) January 26th 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	49	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William Palmer

11 BIRTHPLACE OF FATHER (City or town) (State or country) Eastern Shore Md.

12 MAIDEN NAME OF MOTHER Colon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs. Ida E. Palmer (Address) 2853 W. Garrison ave

Huntington for Williams, M.D. MAY 22 1945 Registrar

For C. W. B. McNally, by Howard J. Thacker, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20-45 19

17 I HEREBY CERTIFY, That I attended deceased from ... 19 30 to May 20 19 45

that I last saw h[illegible] alive on May 4 19 45

and that death occurred, on the date stated above, at 10 40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

Arterio-sclerosis (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard J. Todd M. D.

5/21 19 45 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 PLACE OF BURIAL, CREMATION OR REMOVAL Mrs. W. W. Shreve — Date of Burial 19

16 UNDERTAKER Stevenson Md — ADDRESS

83a

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G29085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G29085 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fernbandt Green

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3025 Mayfield Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marco Scardina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Vita Caruso

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 - 1872

8. AGE: Years	Months	Days	If less than one day
72 73	5	9	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Fruit Merchant

11. Industry or business Owner

FATHER 12. Name Salvatore Scardina

FATHER 13. Birthplace Italy

MOTHER 14. Maiden Name Michela Caruso

MOTHER 15. Birthplace Italy

16 (a) Informant Wife

(b) Address 3025 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 - 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Frank V. Lipsitz

(b) Address 2518 E. Baltimore St

19 (a) (Date received by Registrar) MAY 22 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1945 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14-1945 to 5-20 1945 and that I last saw him alive on 5-20 1945

Immediate cause of death Pulmonary Edema — Duration

Due to Hypertensive C.V.D. & Cerebral

Due to Vascular accident

Other Conditions Poss. pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature F. M. Slaisley M. D.

Address University Hosp. Date signed 5-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29086

JO #93556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G29086

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs. 5 min.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1714 Presbury St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Tate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1945

8. AGE: Years | Months | Days | If less than one day: 5 hr. 5 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James Tate

13. Birthplace Maryland

MOTHER

14. Maiden Name Vivian Potter

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 5-21-45 3 PM (month) (day) (year)

(c) ~~Cemetery~~ or crematory Baltimore City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 MAY 22 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11:55PM 5-9 1945, to 5:AM 5-10-45, and that I last saw her alive on 5-10-45 19

Immediate cause of death	Duration
INTRACRANIAL Hemorrhage	5 hr
CONGENITAL Atelectasis	5 hr
Due to BIRTH Injury	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Clyde's Lunatone; Pend Complete

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H B Perry Jr. M.D.

Address Balt. City Hosp. Date signed 5/10/45 M. D.

VS 150

G29087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

G29087 Registered No.

JO #93547

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 McDonough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1945

8. AGE: Years	Months	Days	If less than one day
			BOA hr. 35 ?min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ballat Farmer
13. Birthplace Louisiana

MOTHER
14. Maiden Name Easie Mae Walker
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 5-18-46 (month) (day) (year)
(c) Cemetery or crematory B.C. Hosp. Crematory
Location 4940 Eastern ave.,

18 (a) Funeral director B.C. Hosp. Crematory
(b) Address 4940 Eastern ave

19 (a) MAY 22 1946 Huntington Williams Md. (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1945, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6:45M 5-9-1945 to 7:20M 5-9-1945, and that I last saw h[illegible] alive on May 9, 1945.

Immediate cause of death INTRACRANIAL Hemorrhage — Duration ½ hr.

Due to Birth Injury

Due to

Other Conditions Prematurity (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Perry Jr. M.D.
Address Balto City Hosp. Date signed 5-20-46 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29088 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 Glyndon Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 71

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Glyndon Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Dorothea Plitt

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Femal | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1871

8. AGE: Years 73 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Louis Plitt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary D. Lembach
15. Birthplace Germany

16 (a) Informant Mrs MAry D. Brown
(b) Address 1306 Glynden Av

17 (a) Burial. (b) Date thereof 5/22/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4618 Park Hgts.

19 (a) (Date received by registrar) MAY 22 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 20 1945. and that I last saw her alive on May 20 1945.

Immediate cause of death: Arteriosclerosis — Duration: 5Yr
Due to: Chronic Myocarditis — 2y
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 2757 W. Mon. Date signed 5/22/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G29089 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. McCabe

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret Winifred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/29/96

8. AGE: Years 49 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B. & O. R.R.

FATHER
12. Name John McCabe
13. Birthplace North Carolina

MOTHER
14. Maiden Name Kaufman
15. Birthplace Baltimore

16 (a) Informant Mrs. Rita Westinghouse
(b) Address 931 Gorsuch ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Balto Co. Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4221 Harford Rd

19 (a) MAY 22 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/1945 at 12:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7/1945 to 5/20/1945 and that I last saw h[illegible] alive on 5/20/1945.

Immediate cause of death: Pneumonia & Cardio-Resp. failure

~~Due to~~ Carcinoma head of Pancreas.

~~Due to~~ Chronic Biliary Fistula

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/18/45

Major findings of operation: Chronic Biliary fistula - Ca Pancreas.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Lawrence M.D.

Address St Josephs Hosp Date signed 5/24/45

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

629090 HEALTH DEPARTMENT—CITY OF BALTIMORE 629090

CERTIFICATE OF DEATH

467

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. The Crawford Retreat St., 5 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Charles J. McCormick

If U.S. Veteran specify WAR

(a) Residence: No. 335 Sh. Chester St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb. 18, 1875

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Ship Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md

FATHER

13. NAME Patrick McCormick

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Margaret Low

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Emma L. Lowe

(Address) 2206 Eyebrook Rd

18. BURIAL, CREMATION, OR REMOVAL

Place Forrest Ridge Date May 25 1945

19. UNDERTAKER John E. Moran

(Address) 3000 E. Baltimore St

No. 21450 ... 19 ... Registrar

MAY 22 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 20, 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1945 to May 21, 1945

I last saw h.im alive on May 19, 1945 Death is said to have occurred on the date stated above, at 9:05 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of the Rectum	July 1944
Gangrene of Perineum & Scrotum	May 20/45

Other contributory causes of importance:

Metastases to Liver & Adrenal Glands.

Was an operation performed? Yes Date of 2/16/45 & 5/21/45

For what disease or injury? Carcinoma of Rectum

Metastases to Liver & adrenal Glands.

What test confirmed diagnosis Tissue Path. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) James L. Owen M. D.

(Address) 18 W. Franklin St. Balto Md.

X

G29091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Mura St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Mura Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Leo Whalen (WHALLAN)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-18-0725

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-15-1894

8. AGE: Years 51 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business John Ruth

FATHER
12. Name Thomas J. Whalen
13. Birthplace Ireland

MOTHER
14. Maiden Name Maryann Gallagher
15. Birthplace Baltimore Md.

16 (a) Informant James Whalen
(b) Address 1800 McCabe Ave.

17 (a) Burial (b) Date thereof 5-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Balto. Md

18 (a) Funeral director George J. Ruth Inc
(b) Address 1735 Druid Park Ave.

19 (a) MAY 22 1945 Huntington, W. Va.
(Registrar's signature) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21/45 19 , at 3:45P M

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John B. Davis, M.D.
Medical Examiner.
Date signed 5/21/45

4 L629092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29092 Registered No. 1316

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Aveve Richardson

3 (b) If veteran, name war: World War # 1
3 (c) Social-Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Beatrice Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 19, 1895

8. AGE: Years	Months	Days	If less than one day
50 49	2	11	hr. min.

9. Birthplace: N. Carolina (Town, county, and state)
10. Usual Occupation: laborer
11. Industry or business

FATHER
12. Name: ? Richardson
13. Birthplace: N.C.

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Bush National Cem.
Location
18 (a) Funeral director Mrs Robert A. Elliott Dept
(b) Address 1129 N. Caroline St.
19 (a) (b) Registrar

MAY 22 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 1945, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 1945, to 5-21 1945, and that I last saw him alive on 5-21 1945.

Immediate cause of death: Uremia — Duration: 1 mo

Due to: Chronic glomerulo-nephritis — Duration: years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Glen Leymaster M.D.
Address J.H.H. Date signed 5/24/45

VS 150

G29093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G29093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5721 Cardinal Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Blair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 3 | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 MAY 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

UNIVERSITY MEDICAL SCHOOL MAY 22 1945 Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1945, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Grayson M.D. Medical Examiner.
Date signed May 11 1945

2716

VS 151

G29094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No. G29094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 MAY 22 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

UNIVERSITY MEDICAL SCHOOL MAY 22 1945 Commissioner of Health

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 8:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions Acute gastritis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 12 1945

12:15

X

G29095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G29095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 North Greene Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 313 North Greene Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLA CAPPA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location ~~UNIVERSITY MEDICAL SCHOOL~~ MAY 22 1945 ~~MARYLAND MEDICAL JOURNAL~~

18 (a) Funeral director ~~Commissioner of Health~~ E. Wallis Tamorsan
(b) Address

19 (a) MAY 22 1945 (Date rec'd by Registrar) (b) Registrar ~~Huntington Williams M.D.~~ Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12/45 19 , at 3:22 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute myocarditis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on a farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Arthur R. Davis, M.D. Medical Examiner.
Date signed 5/13/45

11

93a

G29096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town York Pa (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Prince St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Worsham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 22 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.

Date signed May 25 1945

2743

G29097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29097 (Over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cite the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University Hosp. 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 403 X. Fulton Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Floyd Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Ada Watt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 1885

8. AGE: Years	Months	Days	If less than one day
59	6	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Ship Carpenter

11. Industry or business Bath. Fairfield Co.

FATHER

12. Name John Henry

13. Birthplace Md.

MOTHER

14. Maiden Name Ann E. Kirwin

15. Birthplace Md

16 (a) Informant Mrs Ada Henry

(b) Address 218 S. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24/45 (month) (day) (year)

(c) Cemetery or crematory St. Mathews

Location 6104 O'Donnell St

18 (a) Funeral director Harry A Weitzer

(b) Address 4101 Edmondson Ave

19 (a) Date received by local registrar MAY 22 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 19 45 at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 19 45 to 5/21 19 45 and that I last saw him alive on 5/20 19 45

Immediate cause of death Coronary thrombosis (anterior occlusion) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. Goldstein M.D.

Address University Hosp. Date signed 5/22

VS 150

G29098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29098

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every 'item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-IV
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Cedarcroft Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Shuta

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife late William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 187

8. AGE: Years	Months	Days	If less than one day
74	1	8	hr. min.

9. Birthplace Mary land (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Battenfield
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Barbre
15. Birthplace U. S. A.

16 (a) Informant Mrs Lula Kronefuss
(b) Address 303 S. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2920 Frederick Rd

18 (a) Funeral director Harry A. Wilkes
(b) Address 2191 E Monument St

MAY 22 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945, at 11.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 19 45 to 5/19 19 45, and that I last saw her alive on 5/19 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular disease	6 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2070 Wilkens Ave Date signed 5/21/45

G29099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G29099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD OR BIND

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Preston Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1918

8. AGE: Years	Months	Days	If less than one day
27	3	29	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER — 12. Name	James Brown
FATHER — 13. Birthplace	Balto Md.
MOTHER — 14. Maiden Name	Hannah Beasley
MOTHER — 15. Birthplace	Harford Co. Md.

16 (a) Informant Hanfah Brown
(b) Address 1207 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lucy H. Holland
(b) Address 1345 Division Ave.

19 (a) MAY 22 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945, at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Congenital Malformation and Generalized Hypertrophy of Heart.

Due to

Other Conditions Chronic Valvulitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard I. Weedon M.D. (Medical Examiner.)
Date signed May 20, 1945

G29100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G29100 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division St
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Laurens (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Archie Weaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Wilson, N.C. 3-4-05 1896

8. AGE: Years 49 | Months 2 | Days 15 16 | If less than one day hr. min.

9. Birthplace Wilson, N.C. (Town, county, and state)

10. Usual Occupation Home mkr

11. Industry or business

MOTHER / FATHER

12. Name James Bolden Lyde

13. Birthplace S.C.

14. Maiden Name Mary Davis

15. Birthplace S.C.

16 (a) Informant Winfield Weaver

(b) Address 1419 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Pk

Location Balto Md.

18 (a) Funeral director Mrs. Lee A. Holland

(b) Address 1631 Druid Hill Ave

19 (a) MAY 22 1945 (Date rec'd by registrar) (b) Huntington Williams MR

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1945, at 3 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1945 to 5-20 1945, and that I last saw her alive on 5-20 1945

Immediate cause of death	Duration
Uremia	
Due to Intestinal obstruction	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J L White M. D.

Address Provident Hospital Baltimore Md Date signed 5-20-45 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G29101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Bloom St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Bloom St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carnelius Dowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary A.

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1876

8. AGE: Years 68 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name John H. Dowell

13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden Name Frances Isaac

15. Birthplace Calvert Co Md

16 (a) Informant Mary A. Dowell

(b) Address 517 Bloom St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md.

18 (a) Funeral director Wm. Geo. H. Holland

(b) Address 1621 Druid Hill Ave.

19 MAY 22 1945 (b) Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19 1945, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1945 to 5/19 1945 and that I last saw deceased alive on 5/19 1945

Immediate cause of death Chr. Nephritis & Uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Barkdale Hett M. D.

Address 24 W. Read St Date signed 5/21/45

G29102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29102 / 1318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1003 N. Carrollton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 N. Carrollton Ave. (If rural give location)

(e) Citizen of foreign country? hw (Yes or No) If yes, name country

3 (a) FULL NAME James A. Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1916

8. AGE: Years 29 | Months 2 | Days 15 | If less than one day: hr. min.

9. Birthplace Denver, Va (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Benjamin Pierce

13. Birthplace Prince Co. G. Va

MOTHER 14. Maiden Name Anna Towe

15. Birthplace Blackstone, Va

16 (a) Informant Anna Pierce

(b) Address 1003 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Pk

Location Balto Co. Md

18 (a) Funeral director Mrs. Lee A. Holland

(b) Address 1631 Druid Hill Ave.

19 MAY 22 1945 (Date rec'd by registrar) Thurlington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1945 to May 20 1945 and that I last saw h[illegible] alive on May 20 1945.

	Duration
Immediate cause of death: Chronic parenchymatous nephritis (Uremia)	1 year
Due to: Myocarditis	8 mos
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E. S. Camper M. D.

Address 630 N. Carey St. Date signed 5-22-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G29103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Claude M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1880

8. AGE: Years 64 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George H. Bennett

13. Birthplace Tennessee

MOTHER 14. Maiden Name Lyra Myers

15. Birthplace Tennessee

16 (a) Informant Claude M. Williams

(b) Address 1324 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial P/K

Location Balto. Co., Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) MAY 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945, at 12 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945, to May 21 1945, and that I last saw h[illegible] alive on May 21 1945.

Immediate cause of death: Coronary spasm and arterial

Due to: Arter. sclerosis

Due to: Senility

Other Conditions: Over operation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: None

Duration
1 hr.
1 Yrs.
—
—
—

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M. D.

Address 1632 Druid Hill Ave Date signed 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G29104 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 Guage Court 25 Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Guage Court 25 Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Doshia M. Kiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Stonewall J. Kiser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Marde 17-1917

8. AGE: Years 28 | Months — 2 | Days — 3 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name M. R. Bullard
13. Birthplace North Carolina

MOTHER
14. Maiden Name M. Tipp
15. Birthplace North Carolina

16 (a) Informant Mr Stonewall J. Kiser
(b) Address 1318 Guage Court 25 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24-45 (month) (day) (year)
(c) Cemetery or crematory Montgomery Co Cem.
Location Kannapolis N. C.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St 25 Md

19 (a) (Date received by local registrar) (b) Huntington Williamsport, Md

MAY 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20th 1945 at 11.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to May 20 1945, and that I last saw h alive on May 20 1945.

Immediate cause of death: puerperal Toxemia, eclampsia — Duration

Due to

Due to

Other Conditions chronic cardio vascular disease + pregnancy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. W. Kinter, M.D.

Address 302 Patapsco Ave Date signed 5/21/45 M.D.

X

G29105

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 832

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Seminary
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Very Rev. Vladimir Alexandroff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 74	—	—	— hr. — min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery or crematory St. Charles College
Location Catonsville, Md.

18 (a) Funeral director W. W. Mears and Son
(b) Address Lexington & Holliday Sts.

19 (a) MAY 22 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1944 to May 20 1945, and that I last saw him alive on May 20 1945.

Immediate cause of death Right Cerebral Thrombosis — Duration 2 Yrs/days

Due to

Due to

Other Condition Arterio sclerosis — 6 years
General.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Palagia M. D.
Address 26 Redgrave Place

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Clifton Ave.,
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Clifton Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME A. Stanley Bryan

3 (b) If veteran, name war: W.W. 1

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charlotte M. Bryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1891

8. AGE: Years 53 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Md. (City or county and state)

10. Usual Occupation Deputy Collector

11. Industry or business Dept. of Internal Revenue U.S. Government

FATHER
12. Name A. Stanley Bryan
13. Birthplace Queen Annes Co., Md.

MOTHER
14. Maiden Name Elizabeth MacCubbin
15. Birthplace Va.

16 (a) Informant Mrs. Charlotte M. Bryan
(b) Address 3012 Clifton Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 1945. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

MAY 23 1945 (Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 2.20

20. DATE OF DEATH May 20, 1945 at A.M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1945 to 5/20 1945 and that I last saw him alive on 5/12 1945

Immediate cause of death: Coronary Thrombosis — Duration: 1 year

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Carter M.D.

Address 2145 W Balto St Date signed 5/22/45

X

G29107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G29107

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. PoppletoneSt.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Shipe

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or ~~XXX~~ Edward Shipe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.26,1858

8. AGE: Years 86 | Months 4 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Winchester, Va.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Everhart
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Diffenderfer
15. Birthplace Va.

16 (a) Informant Mrs. Nellie McLaughlin
(b) Address 112 S. Poppleton St.,

17 (a) Burial (b) Date thereof 5-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) MY 23 1945 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1945, at 11.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to May 21 1945, and that I last saw h[illegible] alive on May 21 1945

Immediate cause of death Intracerebral Cerebro-vascular Disease — Duration 3

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osler Johnston MD

Address 2302 Eutaw Pl Date signed 5/24/45 M. D.

X

G29108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 Webb Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Long

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Webb Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar G. Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Anna V. Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14th 1863

8. AGE: Years	Months	Days	If less than one day
82	4	7	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Marcellus Owens
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C (McKeown)
15. Birthplace Md

16 (a) Informant Ross Hackett
(b) Address 1127 Webb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

MAY 23 1945 (Date rec'd by registrar) (b) Huntington Williams Mgr.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1945, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943 to May 21 1945 and that I last saw h~~im~~ alive on May 21 1945

Immediate cause of death: Cirrhosis Myocardial Duration 1940
Due to: Cerebral Sclerosis 1944
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Brown
Address 1663 W. North Ave. Date signed 5/22/45 D.

X

G29109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1578

Registered No. G29109

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 18

(b) Street address 33'RD & CALVERT STS.

(c) Hospital or institution: UNION MEMORIAL HOSPITAL.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS (LIFE)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town BALTIMORE 18, MD.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4113 MARIBAN COURT, BROOKLYN.
(If rural give location)

(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country —

3 (a) FULL NAME MAYNARD CARROLL SLOAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife NONE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 18, 1943

8. AGE: Years	Months	Days	If less than one day
2	2	4	— hr. — min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation CHILD.

11. Industry or business —

FATHER

12. Name ROSCOE M. SLOAN

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden Name DOROTHY BOSWORTH

15. Birthplace WEST VIRGINIA.

16 (a) Informant MRS. ROSCOE SLOAN (MOTHER)

(b) Address 4113 MARIBAN COURT, BROOKLYN BALTIMORE 25, MD.

17 (a) Removal (b) Date thereof 5/23/45
(Burial, Cremation, or removal) (month) (day) (year)

(c) Cemetery Odd Fellows

Location Elkins W. Va

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St.

19 MAY 22 1945 (Date) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 22, 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 21, 1945 to MAY 22, 1945; and that I last saw him alive on MAY 22 1945.

Immediate cause of death	Duration
CARDIO-RESP. FAILURE	50 MIN.
Due to ATELECTASIS	"
Due to ASPIRATION.	"
Other Conditions POST-OP CLEFT PALATE REPAIR. (Include pregnancy within 3 months of death)	5 HRS 45 MIN

Date of operation 5/22/45

Major findings of operation: REPAIR OF CONGENITAL CLEFT PALATE

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul S. Graeff M. D.

Address Union Memorial Hospital Date signed 5-22-45

VS 150

G29110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No. G29110

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland S.
(b) Street address 326 Franklintown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town S. (If outside city or town limits, write RURAL and give town)
(d) Street No. 326 Franklintown Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Weinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of ~~husband~~ wife Julia A. Weinberg

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 25-1866

8. AGE: Years 79 Months 7 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace Alexander Va. (Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Western Md Dairy

FATHER
12. Name Philip Weinberg
13. Birthplace unknown

MOTHER
14. Maiden Name M. Hecht
15. Birthplace unknown

16 (a) Informant Mrs Margaret Dunhart
(b) Address 326 Franklintown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24-45 (month) (day) (year)
(c) Cemetery or crematory Sagsville M.P. Cem
Location Sagsville Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) MAY 22 1945 (Date received by local registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1945 at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 19 45 to 5/21 19 45
and that I last saw him alive on 5/14 19 45

Immediate cause of death arteriosclerosis Gangrene of both legs — Duration 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 2030 Wilkens Date signed 5/22/45

VS 150

X ave

G29111 ✓ G29111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1231a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 Linden Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Latrobe Apts. Charles & Read (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley M. Hanway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife Dec. 18-1875
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 69 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Aberdeen, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Safe Deposit & Trust Co.

FATHER
12. Name Littleton Hanway
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Morgan
15. Birthplace Md.

16 (a) Informant William E. Boyd
(b) Address 1531 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Grove
Location Aberdeen, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1906 Eutaw Place

19 (a) (b) Registrar

MAY 23 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 19 45, to May 21 19 45, and that I last saw him alive on May 21 19 45.

Immediate cause of death: Lacunar Pneumonia

Duration: 5 days

Due to: Hypostatic Pneumonia Cardiac Renal Arteriosclerosis

Duration: 5 years

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Atkinson Mo Jr. M. D.
Address Medical Arts Bldg. Date signed May 23-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62312 X ✓ 62312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Linthicum Hts.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis & Nursery Rds.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick Muller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.) 3/20/1866

8. AGE: Years 79 | Months 2 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Retired Butcher

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace: "

MOTHER 14. Maiden Name: Unknown

15. Birthplace: "

16 (a) Informant: Dorothy C Lantz Wife

(b) Address: Old Annapolis Nursery Rds, Linthicum Hts Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Cem.

Location: East End of North Ave

18 (a) Funeral director: John F. Kenny Inc

(b) Address: 725 Eight St.

19 (a) MAY 23 1945 (Date received by registrar) (b) Registrar: Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1945, at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22/1945 to 5/20/1945 and that I last saw him alive on 5/20/1945

Immediate cause of death	Duration
Cerebral Thrombosis or Pulmonary Embolism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 4/27/45

Major findings of operation: Arteriosclerotic gangrene of Rt. Leg.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles E. Chandler, M.D.

Address: Md Gen'l Hospl Date signed 5/20/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29113 G29113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Darley ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Weiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife Barbara Hagat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16th 1878

8. AGE: Years 66 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business Court House

FATHER
12. Name Jacob Weiss
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Kragel
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Barbara Weiss
(b) Address 1663 Darley Ave.

17 (a) Burial (b) Date thereof 5/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date rec'd by registrar) MAY 23 1945 (Registrar) Huntington W. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1945, at 10 [illegible] P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1945 to 5-19 1945 and that I last saw him alive on 5-19 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 5-19-45

X

G29114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29114

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 S. Fremont
(c) Hospital or institution: [redacted]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 S. Fremont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Gross

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Sydney Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Cal Co. Md
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER
12. Name Samuel A. Gross
13. Birthplace Md

MOTHER
14. Maiden Name Mary Rice
15. Birthplace Md

16 (a) Informant Sydney Gross
(b) Address 636 S Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25-45 (month) (day) (year)
(c) Cemetery or crematory Baths Chapel
Location Calvert Co. Md

18 (a) Funeral director James A Hayes
(b) Address 1542 Ostend St

MAY 23 1945 Huntington Williams M.D.
(Date rec'd by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 , at 11 30 am M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3rd 1945 to 5/21 1945 and that I last saw h alive on 5/20 1945

Immediate cause of death	Duration
Chronic Cerebrovascular Renal disease	
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted]
Address [redacted] Date signed 5/23/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

✓ 629135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4718 Eastern Ave - 2 flr
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr John Thrappas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband or~~ wife Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Store keeper

11. Industry or business

FATHER
12. Name Nicholas
13. Birthplace Greece

MOTHER
14. Maiden Name Eleanor
15. Birthplace Greece

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (month) (day) (year)
(c) Cemetery or crematory Cem.
Location New Greek Cemetery

18 (a) Funeral director J Lambros Fun Hom Inc
(b) Address 438-440 E North ave

19 (a) 5-23-45 (Date rec'd by registrar) (b) Nick Lambros Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1945 at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9 1945 to 5/20 1945, and that I last saw h alive on 5/20 1945.

Immediate cause of death	Duration
Pneumonia	
Due to Obstruction of main bronchus (left)	
Due to Bronchogenic carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose D'Olivary de Chaudens M. D.

Address Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4939 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4939 Reist. Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE BLUCHER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife: Edwin W. Blucher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14 1899

8. AGE: Years	Months	Days	If less than one day
46 47	2	8	hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business.

FATHER
12. Name Wm Corbett
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Balto Co.

16 (a) Informant Grace Tracy
(b) Address Westminster Md

17 (a) Burial (b) Date thereof May 25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Balto. Co

18 (a) Funeral director J. F. Elsin & Sons
(b) Address Reisterstown Md.

MAY 23 1945 (b)
(Date received by local registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1944, to May 22 1945, and that I last saw her alive on May 22 1945.

Immediate cause of death	Duration
(a) Cerebral Thrombosis	2 days
Due to Cerebral Hemorrhage	
Due to Natural Causes	
Due to Hypertension &	
Chronic Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R Hart M. D.
Address 2601 Manhattan Av Date signed 5/29/45

X

G29117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G29117 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 Eyler St
(c) Hospital or institution: South Bond. Bon Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Jeffery St (Rural giv. location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BRICE MESSICK FOXWELL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine Foxwell
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) June 2, 1913

8. AGE: Years	Months	Days	If less than one day
31	11	18	20 hr. min.

9. Birthplace Pleasant Home, Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business Shipfitter

FATHER
12. Name Alonzo W. Foxwell
13. Birthplace Mount Vernon, Md

MOTHER
14. Maiden Name Lola Augusta Foxwell
15. Birthplace Bivalve, Md

16 (a) Informant Father
(b) Address 196 Fillmore, Salis, Md

17 (a) Burial (b) Date thereof May 26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Salisbury Md

18 (a) Funeral director Holloway Co
(b) Address Salisbury Md
(c) Date rec'd by registrar MAY 23 1945 (d) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 3:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1945 to 5/23 1945 and that I last saw h— alive on 5/23 1945

Immediate cause of death Uremia — Duration —

Due to Chronic Glomerulo-nephritis with Malignant Hypertension — Duration ?

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature John M Blake III M. D.
Address South Bond Gen Date signed 5/23/45

Hosp X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G29138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Leyds St.
(c) Hospital or institution: South Bres. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 Da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 RIVERSIDE AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JAMES W. REYNOLDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife ESSIE REYNOLDS
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	20	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name James Reynolds
13. Birthplace —

MOTHER
14. Maiden Name Anderson
15. Birthplace —

16 (a) Informant Family
(b) Address 1149 Riverside Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-25-45 (month) (day) (year)
(c) Cemetery or crematory Dulaney Val.
Location Timber Grove Road

18 (a) Funeral director Jno. H. McCurdy
(b) Address 30 E. Lanvale St.

19 (a) MAY 23 1945 (b) (Registrar's number) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 9.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1945 to 5/22 1945 and that I last saw h alive on 5/22 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Malcolm Allen M.D.
Address South Bres Gen Date signed 5/23/45

Affirmed by Howard J. Madden Hosp. Asst. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29119 | BALTIMORE CITY HEALTH DEPARTMENT | G29119 Registered No.

CERTIFICATE OF DEATH 160a

(over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Stuart Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 - 1945

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name JOSEPH ADOLPH HOFFMAN

13. Birthplace BALTIMORE, MD.

MOTHER 14. Maiden Name DOROTHY ELNOR CREAMER

15. Birthplace BALTIMORE, MD.

16 (a) Informant Dr. of Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave

18 (a) Funeral director John S Connelly

(b) Address 418 Eastern Ave. Room 4

19 (a) (Signature of registrar) (b) Registrar

MAY 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945 to 19..; and that I last saw him alive on May 22 19 45.

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Premature	
Due to Premature Separation of Placenta	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Curral M. D.

Address University Hosp Date signed

G29120
473485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

156a

G29120
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Control Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Clark.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Champ.
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 5-9-13

8. AGE: Years	Months	Days	If less than one day
32	-	13	....hr. ....min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Glen Martin
11. Industry or business

FATHER
12. Name John Lewis
13. Birthplace Penn.

MOTHER
14. Maiden Name Jessie Shultz
15. Birthplace Penn

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY 25-45 (month) (day) (year)
(c) Cemetery or crematory NIOTA-
Location TENN.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eastern Ave.

19 (a) MAY 23 1945 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May-22- 1945, at 1020 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May-7- 1945, to May-22 1945, and that I last saw him alive on May-22 1945.

Immediate cause of death	Duration
Pulmonary embolism	
Due to embolism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 14, 1945
Major findings of operation:
of autopsy: No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Yang M. D.
Address J. H. H. Date signed 5-23-45

Huntington Hollow, Md.
H. C. Yang X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623121 BATZE ✓ 623121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Mainel ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Malta
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Mainel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G Balge

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14.

8. AGE: Years	Months	Days	If less than one day
78	3	8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Juliona
(b) Address 2212 Mainel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Ferndale Rd

18 (a) Funeral director Edward Soulsby
(b) Address 2359 W Pratt Blvd

19 (a) (By whom required) Huntington Willis Registrar

MAY 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1945, to May 22 1945, and that I last saw [illegible] alive on May 21 1945.

Immediate cause of death Carcinomatosis

Due to Carcinoma of Genital Org Duration 21 days

Due to Nephritis Edema Arterio. 6 mo.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R O Adams M.D.
Address 2709 Wallis Ferry Rd Date signed 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Parkside Drive #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES SHERIDAN WILSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carrie A. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1871

8. AGE: Years	Months	Days	If less than one day
73	4	25	hr. min.

9. Birthplace Deals Island, Md.
(Town, county, and state)
10. Usual Occupation Furniture Dealer
11. Industry or business

FATHER
12. Name Lazarus Wilson
13. Birthplace Deals Island

MOTHER
14. Maiden Name Mary Webster
15. Birthplace Deals Island, Md.

16 (a) Informant Mrs. Carrie A. Wilson
(b) Address 3008 Parkside Drive

17 (a) Burial (b) Date thereof 5/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 23 1945 Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1945, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 5/22 1945; and that I last saw h living on 5/22 19 45

Immediate cause of death	Duration
Cerebellar Thrombosis	
Due to Hypertensive C.V. Disease Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Geriatric Hospital Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29123 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G29123

CERTIFICATE OF DEATH 83c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkerson and Catoctin Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1613 W. North Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Lee Roy Whitelock

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-05-6129

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine E.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1884

8. AGE: Years 61 | Months 4 | Days 21 | If less than one day: hr. min.

9. Birthplace Pa - (Philadelphia) (Town, county, and state)

10. Usual Occupation Yard Foreman

11. Industry or business B. & O. R. R.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Catherine E. Whitelock
(b) Address 1613 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 1945 to 5/22 1945, and that I last saw h[illegible] alive on 5/22 1945.

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Cerebral embolism, malacia	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rackoff, M.D.
Address 37 - Agnes Hosp Date signed 5/24/45

Huntington Williams, M.D.

VS 180

X

G29124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G29124

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Woodyear St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Woodyear St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Bannister

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife Daisy Bannister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Annapolis md
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name James Bannister
13. Birthplace md

MOTHER
14. Maiden Name Emma —
15. Birthplace md

16 (a) Informant Theodore Bannister
(b) Address 1702 Woodyear St

17 (a) Burial (b) Date thereof 5-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George E. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) MAY 31 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21/1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1945 to 5/21 1945 and that I last saw him alive on 5/20 1945

Immediate cause of death Cerebral apoplexy — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Rhett M. D.
Address By Dr. Rhett Date signed 5-24-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC. 629.25 G246v2 629.25

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2840 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BABY BOY SHORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 3 days | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Manuel Shore
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Selina Pell
15. Birthplace Balto Md

16 (a) Informant Mother
(b) Address 2840 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location PHIL ROT BOWLEYS LANE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 25 1945

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1945 to 5/22 1945 and that I last saw h[illegible] alive on 5/22 1945

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 5/23/45

VS 3

G29126 G29126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution SINAI HOSPT 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 ELLAMONT RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEIN, LOUIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife ANNA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (b) Date thereof 5-23-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location PHIL RD + BOWLEYS LANE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) MAY 23 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1945, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1945 to 5/23 1945 and that I last saw h. alive on 5/23 1945

Immediate cause of death Cardiac Insufficiency — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman M. D.

Address Sinai Hospital Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G29127 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner & Dulaney Ave.

(c) Hospital or institution West Balt. Gen. Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2¼ mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 638 N. Fulton Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** ISADORE L. ~~ADLER~~ ADLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Aaron Laird —

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Bernman

15. Birthplace Russia

16 (a) Informant Harry Hanover

(b) Address 2911 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (month), (day), (year)

(c) Cemetery or crematory Windsor Mill Rd

Location

18 (a) Funeral director Jacob Levine Inc

(b) Address 1439 E. Balto St

19 (a) MAY 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1945 to 5/22 1945 and that I last saw h[illegible] alive on 5/22 1945.

Immediate cause of death POSSIBLE ENCEPHALITIS

Due to SECOND AND THIRD DEGREE BURNS WITH SECONDARY INFECTION

Due to

Other Conditions EPILEPSY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 11

(a) Accident, suicide, or homicide ACCIDENT (ACCIDENT)

(b) Date of occurrence 3/16/45 at 7P M

(c) Where did injury occur? BALT, MD. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO

(e) Means of injury BURNED DURING EPILEPTIC SEIZURE IN BATH TUB

23. Signature A. Silberfeld M. D.

Address [illegible] Date signed 5-23-45

VS 150

Approved by Howard J. Malecki, M.D.

G291128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G291128 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Blum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 78 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-37 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1937, at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1937 to May 23 1937 and that I last saw h[illegible] alive on May 23, 1937.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr.
Due to Hypertension Cardiovascular Disease	2-3 yrs.
Due to Generalized Arteriosclerosis	3
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Philip J. Lewis
Address 2401 W. North Ave Date signed 5/23/37 D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G29129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G29129 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 BOORMON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** LOUIS EPSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-9943

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife SARAH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months — | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation PRESSER

11. Industry or business

FATHER 12. Name BENJAMIN
13. Birthplace RUSSIA

MOTHER 14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-23-45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location O'DONNEL ST

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

19 (a) MAY 23 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1945, to 5/22 1945, and that I last saw h[illegible] alive on 5/22 1945.

Immediate cause of death Pulmonary edema 4
atelectasis

Due to C-2 fracture

Due to Carcinomatous injury - stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Farber, M.D.

Address [illegible] Date signed 5/23/45

Witness [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6[illegible]0

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 North Ave
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA LITCHENSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife ABRAHAM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Asch Plonsky
13. Birthplace Russia

MOTHER
14. Maiden Name Klug
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 5-23-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Oldest Ry & Hamilton Ave

18 (a) Funeral director Earl Lewis Lee
(b) Address 1435 E. Balto St

19 (a) MAY 23 1945
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23/45 19 , at 3:30 A M

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 5/23/45

G29131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G29131

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 ST Paul ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edith Lulu Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-1878.

8. **AGE:** Years 67 Months 2 Days 0. If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired Teacher

11. Industry or business Balto. City Schools

FATHER
12. Name John T. Ford
13. Birthplace Md.

MOTHER
14. Maiden Name Hester Rebecca Wrightson
15. Birthplace Md.

16 (a) Informant Mrs William Osborn
(b) Address 11 Club Rd. City 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26 (month) (day) (year) 45

(c) Cemetery or crematory Olivet Cemetery
Location St Michaels, Md.

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) MAY 25 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 5-22 19 45 at 5:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17 19 45 to 5-22 19 45, and that I last saw her alive on 5-22 19 45.

Immediate cause of death C-R Failure — Duration

Due to Cerebral metastasis

Due to Carcinoma colon. (ascending)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** J. Frank Supplee, M.D.
Address Union Memorial Hospital Date signed 5/22/45

VS 150

G29132

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29132 Registered No. 1220

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. Gen. Hosp. 1200 Light St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Marie Wingate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: wh | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Clarence Wingate

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 29 1895

8. AGE: Years	Months	Days	If less than one day
49	10	22	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George A. Durst
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Stella Pentz
15. Birthplace: Balto. Md.

16 (a) Informant: Clarence Wingate
(b) Address: 1238 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 24 1945 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Ritchie Highway

18 (a) Funeral director: Fred A. Fridus & Son
(b) Address: 1216 S. Charles St

19 (a) MAY 22 1945 (Date received by Registrar) (b) Livingston Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21-45 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16-45, to 5-21-45
and that I last saw her alive on 5-21 1945

Immediate cause of death: Heart failure

Due to: Hypertension

Due to:

Other Conditions: [redacted] Post operative (Include pregnancy within 3 months of death)

Date of operation 5-21-45

Major findings of operation: Large ventral Hernia

of autopsy: Not done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.
Address: [illegible] Balto. Gen. Hosp. Date signed

X 5/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Archie J. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9340

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Emma Madora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10-1889

8. AGE: Years 55 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace [illegible] Crewe Va. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Brogue Dept Store

FATHER 12. Name Thomas Williams

13. Birthplace Va

MOTHER 14. Maiden Name Martha Bulett

15. Birthplace Va

16 (a) Informant Amanda Chatmond

(b) Address Crewe, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-45 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr

(b) Address 117 N. Carrollton Ave.

19 (a) MAY 25 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1945 at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Madora M.D. Medical Examiner.

Date signed 5-29-45

VS 151

G29134 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G29134

CERTIFICATE OF DEATH 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 549 Bayside Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella E. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George L. Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1881

8. AGE: Years 64 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Roma J. Ahl
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. McCafferty
15. Birthplace Maryland

16 (a) Informant Vernon L. Dorsey
(b) Address 549 Bayside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) MAY 23 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1945, at 5 48 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Spleen
Laceration of Lung

Due to

Other Conditions Multiple fractures, lacerations, abrasions, bruises & contusions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/22/45 at 12/7 40 P. M.
(b) Where did injury occur? Howard St. at 24th Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Pedestrian, struck by auto

23. Signature Howard J. Ulrich M.D.
Medical Examiner.
Date signed 5-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G29135

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2938 Westwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2938 Westwood Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rebecca Rosenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 16, 1875

8. AGE: Years	Months	Days	If less than one day
69	5	7	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Domestic Work

FATHER

12. Name Bernard Podlinsky

13. Birthplace Russia

MOTHER

14. Maiden Name Unkown

15. Birthplace Russia

16 (a) Informant Mrs Joseph I. Bellus

(b) Address 2938 Westwood Ave

17 (a) Burial (b) Date thereof May 24, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) MAY 23 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 3.35

20. DATE OF DEATH May 23, 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945 to May 23 1945 and that I last saw h[er] alive on May 22, 1945

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerosis Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Sol Levinson M. D.

Address 2938 Eastern Ave Date signed 5/24/45

VS 150

629136 HEALTH DEPARTMENT—CITY OF BALTIMORE 629136

CERTIFICATE OF DEATH ✓107

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3114 Garrison Blvd St., 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Oldham

(a) Residence: No. 3114 Garrison Blvd St., Ward 15
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, ~~widowed, or divorced~~ (or) WIFE of David J. Oldham

6. DATE OF BIRTH (month, day, year) June 24. 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Paterson N. J

FATHER

13. NAME Sidney H Hammond

14. BIRTHPLACE (city or town) (State or country) ✓

MOTHER

15. MAIDEN NAME Sarah Groves

16. BIRTHPLACE (city or town) (State or country) Canada

17. INFORMANT (Address) Mrs Earl S Fox 3114 Garrison Blvd

18. BURIAL, CREMATION, OR REMOVAL
Place Cedar Knoll Cem Paterson N J Date 5/23/45. 19

19. UNDERTAKER (Address) Wm Pickney Sons North & Pa Ave.

20. FILED MAY 23 1945 Hunter for Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH ✓

21. DATE OF DEATH (month, day, year) May 22, 1945

22. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1944 to May 22, 1945

I last saw h[illegible] alive on May 22, 1945 Death is said to have occurred on the date stated above, at 6.20 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchiectasis C cavitation - Rt. Lung.	
Other contributory causes of importance:	
Bronchopneumonia	4-15-45
Arteriosclerosis	?

Was an operation performed? No Date of

For what disease or injury?

Clinical Exam. Exams.

What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external cause (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Charles F Warner M. D.

(Address) 3912 Edgerton Road

106 B

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

G29137, Trans

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G29137
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2431 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs or more

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2431 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Bettie Hicks

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 4, 1884
8. AGE: Years 60 | Months 8 | Days 20 | If less than one day hr. min.
9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jack Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie Smith
15. Birthplace Va.

16 (a) Informant Hattie Mrs Anderson
(b) Address 2431 Druid Hill Ave.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Dundee Virginia
18 (a) Funeral director Mrs. Roberts Ellington
(b) Address 1299 N. Caroline St.
19 (a) (b) Registrar

MAY 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945, at 7.30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945, to May 21 1945, and that I last saw her alive on May 21 1945.

Immediate cause of death	Duration
Paralysis	4 days
Due to	
Due to	
Other Conditions Cerebral Haemorrhage	widel

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature X
Address 117 W. 25th St Date signed May 23, 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St Michaels - 7 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Father William Knell

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Rochester N.Y. (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant HOSPITAL RECORDS
(b) Address MERCY HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 26/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Tully & Tully
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) MAY 23 1945 (b) Huntington Hills Secretary

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1945, at 6.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1945 to May 22 1945 and that I last saw him alive on May 22 1945.

Immediate cause of death	Duration
Cardiac failure (post operative)	3
Due to arteriosclerotic CVD	?
Due to	
Other Conditions Cardiospasm	?

(Include pregnancy within 3 months of death)

Date of operation 5/16/45
Major findings of operation: Cardiospasm
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy B. Sawyer, Jr. M. D.
Address Mercy Hospital Date signed 5/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

629139 Registered No.

AB-93740

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.-40min

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County BALTO.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

Street No. 116 S. Maderia St. (If rural give location)

(e) Citizen of foreign country? Rural (Yes or No)

If yes, name country

3 (a) FULL NAME Raymond Naylor

3 (b) If veteran, name war: W.W.# 1

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary NAYLOR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1895

8. AGE: Years 50 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (town, county, and state)

10. Usual Occupation LABORER

11. Industry or business BALTO.CITY

FATHER

12. Name UNKNOWN

13. Birthplace UNKNOWN

MOTHER

14. Maiden Name UNKNOWN

15. Birthplace UNKNOWN

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 25/45 (month) (day) (year)

(c) Cemetery or crematory ST. MATTHEW

Location ODONNELL ST.

18 (a) Funeral director Lilly & Geiler Inc

(b) Address 403 S. WOLFE ST.

19 (a) MAY 29 1945 (b) Registrar

Date rec'd by registrar

Waiting for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21- 19 45, at 5.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21- 19 45, to 5-21 19 45, and that I last saw him alive on 5-21 1945.

Immediate cause of death: Coronary occlusion — Duration: 6 hrs?

Due to:

Due to:

Other Conditions: Gen Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 5-22-45

VS 150

Dr. J. B. Boyle
5217 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √83a

Registered No. 429140

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Batavia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Batavia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie L. Perry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John J. Perry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1876

8. AGE: Years	Months	Days	If less than one day
68	6	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Shipley
13. Birthplace Howard Co.

MOTHER
14. Maiden Name Annie R. Pitt
15. Birthplace Howard Co.

16 (a) Informant Mrs. Ruth Wheeden
(b) Address 3301 Batavia Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 23 1945 (date received by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945, at 1. P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to May 21 1945, and that I last saw h alive on May 21 1945.

Immediate cause of death Cerebral Hemorrhage.
Due to Arteriosclerosis
Malignant Hypertension.
Due to MALIGNANT
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Brooke Boyle M. D.
Address 5217 Harford Rd Date signed 5/22/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G2914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G2914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Hoffman Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Zelvis (Zelvicis)

3 (b) If ~~Veteran~~ r — 3 (c) Social Security Account No. 213-03-6513 213-03-4499

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation tailor
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Agnes Zelvis
(b) Address 1812 Hoffman ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd
18 (a) Funeral director Joseph Rosenstein Inc
(b) Address 602 Washington Place
19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MAY 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 1945 at 9 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1945 to 5-21 1945 and that I last saw h~~im~~alive on 5-21 1945

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Cerebral vascular accident	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. K. Kozman M. D.
Address Franklin Sq Hosp Date signed 5-21-45

Nephi K. KEZERIAN X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29142 G29142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 347 Charles St
(c) Hospital or institution Cambridge Dorms Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 347 Charles
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred George

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sallie M. George

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov-3-1867

8. AGE: Years 77 | Months 6 | Days 18 | If less than one day: hr. 0 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired from
11. Industry or business C & O Ordnance Co.

FATHER
12. Name Alfred George
13. Birthplace Balto Md

MOTHER
14. Maiden Name Ellen Shriver
15. Birthplace Balto md

16 (a) Informant Mrs Sallie M. George (wife)
(b) Address Cambridge Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May-24-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Steward Memorials,
(b) Address 1081 W North Ave.

19 (a) MAY 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1945 to May 21 1945 and that I last saw him alive on May 20 1945.

Immediate cause of death: Acute Dilatation of Heart — Duration: Immediate

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury 18

23. Signature G. Lebrun Ernst M.D.
Address 2945 St Paul St Date signed 5/22/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29143

G29143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 BRICE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 41YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 BRICE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ALBERT K. BEHRENDT

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-0625

4. Sex M.

5. Color or race WHT

6 (a) Single, married, widowed or divorced MARRIED

6 (b) Name of ~~husband~~ or wife SOPHIA

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) SEPT. 2. 1882

8. AGE: Years 63 | Months 8 | Days 12 | If less than one day hr. min. 18

9. Birthplace GERMANY.
(Town, county, and state)

10. Usual Occupation RIGGER

11. Industry or business ALBERT C. HURD CO

FATHER
12. Name ALBERT BEHRENDT
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant SOPHIA BEHRENDT
(b) Address 504 BRICE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/23/45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location FRED AVE

18 (a) Funeral director GEO LEIMBACH
(b) Address 325 N LYNDHURST ST

19 (a) MAY 23 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11/1943, to 5/20/1945, and that I last saw him alive on 5/19/45

Immediate cause of death: Hypertensive cardio vascular disease; coronary thrombosis. — Duration: 2 yrs.

Due to:

Due to:

Other Conditions: Broncho-pneumonia — Duration: 3 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M.D.

Address 1226 Hanover St. Date signed 5/21/1945.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G29144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Rutland Ave.
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Lillie) Lillian May Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife David E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 20 1869
8. AGE: Years 75 | Months 8 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Chalk
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Edward Williams
(b) Address 1219 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director William Lee Jones
(b) Address 1219 Rutland Ave

19 (a) MAY 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1945 to 5/23 1945 and that I last saw h[illegible] alive on 5/23 1945.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	3 yr
Due to	
Due to Myocardial degeneration	4 day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Miller M.D.
Address 1500 N Broadway Date signed 5/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 3-1B

Registered No. 629145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman M. Hasslook

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Kathryn Hasslook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10th 1875

8. AGE: Years	Months	Days	If less than one day
69	9	13	hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual Occupation: Plumber
11. Industry or business: Self

FATHER
12. Name: Henry M. Hasslook
13. Birthplace: Germany

MOTHER
14. Maiden Name: Minnie Hinderwitz
15. Birthplace: Balto. Md.

16 (a) Informant: Kathryn Hasslook
(b) Address: 1919 Harlem Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul ST.

19 (a) MAY 24 1945 (Date rec'd by registrar) Wellington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23rd 1945 at 12 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940 to May 23 1945, and that I last saw h[illegible] alive on May 22 1945

Immediate cause of death: Coronary Occlusion, Heart — Duration: 8 months

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature: Norma B. Schreiber M. D.
Address: 4 S. Fulton Ave Date signed: 5-23-45

VS 150

Roche ✓

629146 BALTIMORE CITY HEALTH DEPARTMENT 629146

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 Mont L Calhoun
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1448 West Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Roche

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ Catherine Roche

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) about Jan 10 1863

8. AGE Years about 78 | Months 11 | Days 11 | If less than one day hr. min. 18

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation None

11. Industry or business Retired

FATHER 12. Name Unknown Roche

13. Birthplace "

MOTHER 14. Maiden Name ? (Unknown)

15. Birthplace "

16 (a) Informant ?

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill

Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St Paul St.

19 (a) MAY 24 1945 (Date rec'd by registrar) (b) Huntington Hiss Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21/45 19 at 6:45 PM

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Weiss Medical Examiner M.D.

Date signed 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29127 ✓ G29127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 - Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lawrence Davidson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 mths 3 23 45

8. AGE: Years | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oliver Davidson
13. Birthplace N. Y. N. Y.

MOTHER
14. Maiden Name Rose Bendelsamp
15. Birthplace Pennsylvania

16 (a) Informant Elena Davidson
(b) Address 3044 - Chesterfield Ave

17 (a) 5-24-45 (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morland
Location Taylor Ave.

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Holford Rd.

19 (a) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945, to May 23 1945, and that I last saw h[illegible] alive on May 23 1945.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Atelectasis, hypostatic	
Due to:	
Other Conditions:	
(Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of [illegible]: Atelectasis and Pneumonia	
of autopsy: bilateral	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury #
23. Signature H. F. Rolfes M. D.
Address Mercy Hospital Date signed 5/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

X ✓ G29148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baeto Co
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Meadow Brook (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estella J. Carey.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	w	Married

6 (b) Name of husband or wife Milbert N Carey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1900

8. AGE: Years	Months	Days	If less than one day
45	3	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Chas Mosbergau.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Catherine Vernon
15. Birthplace Maryland.

16 (a) Informant Milbert Carey
(b) Address 112 Meadow Brook Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leland MacNabb
(b) Address Catonsville Md

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar
MAY 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945 to May 22 1945; and that I last saw her alive on May 22 1945.

Immediate cause of death	Duration
Cardio Resp - Failure	
Due to Pneumonia Bronchitis & Chronic nephritis	
Due to	
Other Conditions Cellulitis L left arm.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clyde Rutledge, Jr., M.D. M. D.
Address 19 E. Lanvale St Date signed 5/23/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29149 ✓ G29149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4514 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cleveland Walker. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jennie Walker
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept 24 1872

8. AGE: Years 72 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business R. way - Yard

FATHER
12. Name John T Walker.
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Thompson
15. Birthplace ?

16 (a) Informant Charles Walker.
(b) Address 4533 Schenley Rd. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24/45 (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Emanuel J. Donovan
(b) Address 3615-17 Eastern Ave

19 (a) (b)
(Date received by Registrar) Registrar

MAY 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 1945, at 12:00 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1945 to 5-21 1945 and that I last saw h. in life on 5-21 1945.

Immediate cause of death — Duration

C-R failure - ~~cor pulmonale~~ ~~hypertension~~

Due to Pneumonia - bronchial

Due to Urinary retention & benign prostatic hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchiah Sprague M.D.
Address 4 M H Date signed 6-21-45

G29150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G39150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs. 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 6115 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Beulah Brookhart

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1945

8. AGE: Years	Months	Days	If less than one day
	3	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Benjamin O. Brookhart Jr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Vickers
15. Birthplace Georgia

16 (a) Informant Mother
(b) Address 6115 Falls Road Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date there May 25/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Edmondson-Corpeau
(b) Address 3615-17 Eastern Ave.

19 (a) (Date rec'd by registrar) MAY 28 (b) 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945, to May 23 1945, and that I last saw her alive on May 22 1945.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Congenital Heart disease	
Due to	
Other Conditions Bronchopneumonia, bilateral. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul S. Cooper M. D.
Address Union Memorial Hospital Date signed 5-23-45

VS 150

629151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

Registered No. 629151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Glenarm Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Magill

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/45

8. AGE: Years	Months	Days	If less than one day
			4 hr. 34 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Frederick Joseph Magill
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Thelma Byrne
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Thelma Magill
(b) Address 4305 Glenarm Ave.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilson Undertaking Co Inc
(b) Address 1217 E Fort Ave

19 (a) [illegible] (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23/45, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1945 to 5/23 1945, and that I last saw her alive on 5/23 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Premature birth.	4 hr 34 min
Due to	
Other Conditions Born by Caesarean Section	

(Include pregnancy within 3 months of death)

Date of operation 5/23/45
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. Hohenemser M.D.
Address Mercy Hospital Balto. Md. Date signed 5/24/45

VS 150

G291532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G291532

JO # 93712

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1057 Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Judge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1907

8. AGE: Years	Months	Days	If less than one day
38	1	?	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Lewis Judge
13. Birthplace South Carolina

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Miranus A. Hinkley
(b) Address 578 W. Biddle St.

19 (a) MAY 24 1945 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1945, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20, 1945, to May 21, 1945, and that I last saw him alive on May 21, 1945.

Immediate cause of death	Duration
Pulmonary failure	?
Due to	
Due to	
Other Conditions Lobar pneumonia, Pneumococcic meningitis (Include pregnancy within 3 months of death)	?
Date of operation	
Major findings of operation:	
of autopsy: None	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elwood Lucas M. D.
Address Baltimore City Hospitals Date signed 5-22-45

X

G29153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

G29153 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 S. Schroeder st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life Time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Schroeder St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Grayson Lowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Lowman
(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 3 11 1881

8. AGE: Years	Months	Days	If less than one day
64	2	4	hr. — min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Margaret Lowman
(b) Address 131 S. Schroeder st

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 5. 25. 45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Single Interment

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor st

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)
MAY 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24/45 19 ..., at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/45 19 to 5/24/45 19 ..., and that I last saw h[illegible] alive on 5/15/45 19 ....

Immediate cause of death Obstruction — Duration Hours

Due to Cancer Cardiac end of Stomach — Duration Weeks

Due to ..... — Duration Months

Other Conditions Treated at Cunningham City Hosp. the Bruced Hospital Baltimore — Duration Years

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Walter F. Loder M.D.
Address 401 Edmondson Date signed 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29154 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 White Chapel Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and name town)
(d) Street No. 3503 White Chapel Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolf Buchdahl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Paula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Germany

MOTHER
14. Maiden Name Frowd
15. Birthplace Germany

16 (a) Informant Paula Buchdahl
(b) Address 3503 White Chapel Rd

17 (a) Cremation (b) Date thereof 5-25-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druden Park
Location

18 (a) Funeral director Jack Reiss Inc
(b) Address 1434 E. Balto St

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 2.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19 to May 23 1945, and that I last saw h[illegible] alive on May 23 1945.

Immediate cause of death: Cerebral hemorrhage

Due to: Hypertension - Cardio-vascular disease and

Due to: Arteriosclerosis

Other Conditions: Hemiplegia of right side 1 year ago
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature 2301 Eutaw Place [illegible] M. D.
Address LAfayette 0373—Baltimore 17, Md. Date signed [illegible] M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

629155 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2948 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2948 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Meid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	W.

6 (b) Name of husband or wife Mary C. Hoffner.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1866

8. AGE: Years	Months	Days	If less than one day
78	9	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER
12. Name Geo. Meid
13. Birthplace Ger.

MOTHER
14. Maiden Name Eva Hass
15. Birthplace Ger.

16 (a) Informant Family
(b) Address 2948 Harford Rd.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-25-45 (month) (day) (year)
(c) Cemetery or crematory Loudenwood.
Location Taylor Ave.

18 (a) Funeral director Mrs. Mary Boutchard
(b) Address 2839 Parkview Ave.

19 (a) (Date received by registrar) (b) Registrar

MAY 24 1945 Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945, to May 22 1945; and that I last saw him alive on May 22 1945.

Immediate cause of death: Chronic myocarditis — Duration 3 years

Due to

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature L. L. Gordy M. D.
Address 5706 Harford Road Date signed 5-25-45

623156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

623156 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1948 Ridgehill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Zerrlaut

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26 - 1889

8. AGE: Years 55 | Months 6 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Fire Department

11. Industry or business No. 12 Truck.

FATHER 12. Name Edmond Zerrlaut.

FATHER 13. Birthplace Kentucky

MOTHER 14. Maiden Name Emeline Clark.

MOTHER 15. Birthplace Elliott City Md.

16 (a) Informant Mrs. Della B. Zerrlaut

(b) Address 1948 Ridgehill ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26-1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Balto. Md.

18 (a) Funeral director Francis Corbyfer

(b) Address 1600 W. North Ave Washington Maryland, Md.

19 (a) MAY 28 1945 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1945, at 5.35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G291.57 ✓ G291.57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 31 Q

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 E. Chase St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susan J. Boland

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John J. Boland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 9, 1862

8. AGE: Years: 83 | Months: 0 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs. Margaret T. Boland
(b) Address: 928 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 26/45 (month) (day) (year)
(c) Cemetery or crematory: Mount Cathedral Cemetery
Location: 4300 Old Frederick Rd

18 (a) Funeral director: Elmer W. Conkling Son
(b) Address: 524 E. Eager St

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams

MAY 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945 at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to May 23 1945.
and that I last saw her alive on May 21, 1945

Immediate cause of death: Chronic Myocarditis

Due to: Arteriosclerotic Cardiovascular Renal Disease.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel P. Wolfe.
Address: 1331 Eutaw Ave Date signed: 5-25-45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623138 ✓ 623138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town).
(d) Street No. 1229 Scott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY VOSSBRING

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~ or ~~divorced~~.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 13, 1866

8. AGE: Years	Months	Days	If less than one day
79		10 9	hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name Unknown.
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Mitzgerw
(b) Address 1229 Scott st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location W. North ave

18 (a) Funeral director Ambrose Insley
(b) Address H14 N Franklintown rd

19 (a) MAY 24 1945 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May 22, 1945, at 10:4M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 22 1945 10 A.M.
(b) Where did injury occur 1229 Scott ST
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self

23. Signature Robert Lee Bratton M.D. (Medical Examiner.)
Date signed May 22 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(29159)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. (29159)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219½ E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219½ E. North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minerva R. King

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward S. King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1883

8. AGE: Years 61 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Murphy
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ella V. Richards
15. Birthplace Maryland.

16 (a) Informant Edward S. King
(b) Address 219½ E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2161 Frederick Ave.

19 (a) MAY 24 1945 (Date rec'd by registrar) (b) Filed * Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6- 1944, to May 24 1945, and that I last saw her alive on May 24 1945.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Paroxysmal Tachycardia	2 yrs
Due to	
Other Conditions Chronic Myocarditis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Wall M. D.
Address 1631 E North Ave Date signed 5/24/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5231.60 472752 6231.60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 51

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Loanoke
(c) City or town Baltimore - Irvington (If outside city or town limits, write RURAL and give town)
(d) Street No. 352 Maydell Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Falkenhahn

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Theodore
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 6-1-1888

8. AGE: Years 56. | Months 11 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Bernard Oberkiel
13. Birthplace Germany.

MOTHER 14. Maiden Name Virginia Zeitler
15. Birthplace Germany.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-26-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto County, Md.

18 (a) Funeral director Geo. W. Yahnert
(b) Address 210 Frederick Ave.

19 (a) MAY 24 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May. 24 1945 at 4.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1945 to May-24 1945, and that I last saw h.. alive on May 24 1945.

Immediate cause of death	Duration
(a) Primary Tumor (Glioma) - post Operative	
Due to: Post-Operative Pneumonia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/24/45

Major findings of operation: Inoperable Post Orbital base tumor

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth W. Saunders M. D.
Address Ruth Johns Hopkins Hosp. Baltimore, Md. Date signed 5/24/45

G2161 — Mr Harper, 3534 Ellerslie Ave — G2161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97 — Registered No. G2161

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 East 37th St.
(c) Hospital or institution: 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 East 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WILLIAM ~~HENRY~~ F. DENNY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Elizabeth J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30. 1862

8. AGE: Years	Months	Days	If less than one day
82	8	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Railroad Man Retired
11. Industry or business Penna Railroad

FATHER
12. Name George Denny
13. Birthplace Pa

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa

16 (a) Informant George Denny
(b) Address 3705 Old York Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery or crematory Laurel Mem Park.
Location Egg Harbor - N. J.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St Baltimore, Md

19 (a) MAY 24 1945 (Date rec'd by registrar) (Huntington for Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 24 May 1945 to 24 May 1945, and that I last saw h~~e~~ alive on 24 May 1945

Immediate cause of death arterio-sclerosis — Duration 5 yrs(?)

Due to

Due to

Other Conditions Age and exhaustion from long bed tread this
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huntington Cooper

Address 3534 Ellerslie Ave Date signed 24 May 45 (M. D.)

VS 150 (over) — for H. B. McKelly, by Thomas J. Chevalier, M.D. X

G29162 G29162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 544 Oxford Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joan Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 | 13 | 45

8. AGE: Years	Months	Days	If less than one day
	3	9	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name John Boyd
13. Birthplace Georgia

MOTHER 14. Maiden Name Evelyn Fitzgerald
15. Birthplace Virginia

16 (a) Informant John Boyd
(b) Address 544 Oxford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAY 24 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 19 45, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease (Patent interventricular septum)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 22 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29163 G29163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH S 6 E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 REGESTER AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. JUCKES
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MRS. M. LDA W JUCKES
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) DEC. 12, 1894

8. AGE: Years	Months	Days	If less than one day
50	5	11	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation MANAGER
11. Industry or business Coastwise MARITIME CO.

FATHER
12. Name ALLAN R JUCKES
13. Birthplace ENGLAND

MOTHER
14. Maiden Name LUCY MORGAN
15. Birthplace ENGLAND

16. (a) Informant Mrs. Mathilda Juckes
(b) Address 714 Regester Ave 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory Mayland Mem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. Md.

19 (a) MAY 24 1945 (Date rec'd for record) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1945, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1945 to 5/23 1945 and that I last saw h.i.m alive on 5/23 1945

Immediate cause of death CARDIAC FAILURE — Duration

Due to DEBILITY

Due to OSTEO CHONDRIMA

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/27/43

Major findings of operation: OSTEO CHONDROMA OF FEMUR

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul J. Herold
Address Md. General Hosp. Date signed 5/23/45 M. D.

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29164

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 Edmondson Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Edmondson Ave.
(If rural-give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA E. CANNON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Walter Cannon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	15	hr. min.

9. Birthplace Queen Anne Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lane
13. Birthplace Centerville, Md.

MOTHER
14. Maiden Name Alice V. Hunter
15. Birthplace Centerville, Md.

16 (a) Informant Mrs. Emma Cannon
(b) Address 1920 Edmondson Ave.

17 (a) Burial (b) Date thereof 5/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 24 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1945, at 2:50PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 to May 22 19 45
and that I last saw h alive on May 22 19 45

Immediate cause of death

	Duration
Arteriosclerosis	3 yrs.
Due to Arteriosclerotic Cardiac Disease	
Due to Diabetes	
Other Conditions Acute Cardiac Dilatation	1 day

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Quigley 5/27/45 M.D.
Address 1000 Cathedral (Date signed)

G29165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45

Registered No. G29165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Hyson Street (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME RAYMOND CORNELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 24 1917

8. AGE: Years	Months	Days	If less than one day
27	7	28	.....hr. .....min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Albert Cornell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Thompson
15. Birthplace Balto. Md.

16 (a) Informant Mr Albert Cornell
(b) Address 610 Hyson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 25 45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Anne Arundel County

18 (a) Funeral director John H. Welsh
(b) Address 401 S. Chester Street

19 (a) MAY 26 1945 (Date rec'd by Registrar) (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1945, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory Failure

Due to Status epilepticus

Other Conditions Tinea capitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 25 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6291.66

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

6291.66 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Louise Leader

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Julius J. Leader
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1870

8. AGE: Years 74 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: George Schelhase
13. Birthplace: Germany

MOTHER
14. Maiden Name: Christina Betz
15. Birthplace: Germany

16 (a) Informant: Miss Maria Irene Leader
(b) Address: 1601 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1945 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore

18 (a) Funeral director: Rita Wiedefeld
(b) Address: 914 Greenmount Ave

19 (a) MAY 24 1945 (Date filed by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 12:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1945 to May 23 1945 and that I last saw h[illegible] alive on May 22 1945

Immediate cause of death: Uremia Coma — Duration: 2 days
Due to: Apoplexy — 5 days
Due to: Arteriosclerosis — Several years
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: G. Lahrde Ewalt M. D.
Address 29 40 St Paul St Date signed May 24/45

Dr G. Ewalt 1900 St Paul St

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

629167 Registered No. 1940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD J. NORWOOD

3 (b) If veteran, name war Spanish
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Matilda S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1877

8. AGE: Years 68 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Eng Engineer
11. Industry or business Hemp Twine Co

FATHER
12. Name Norwood
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name ?
15. Birthplace Balto. Md.

16 (a) Informant Henry Eschelle
(b) Address 608 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.

18 (a) Funeral director John J. Madden
(b) Address 4201 Greenmount Ave

19 (a) MAY 24 1945 (Date filed by Registrar) (b) Huntington Hollins, MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23/45 19 at 6:25 A.M.

21. I certify that I took charge of the remains described above, held an autopsy, inspection or inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John J. Madden M.D.
Medical Examiner.
Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1464

Registered No. 629168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 82
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 S. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Terzano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of ~~husband~~ or wife Carmela Terzano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/17/1872

8. AGE: Years	Months	Days	If less than one day
72.	11	3	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lenard Terzano
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Tano
15. Birthplace Italy

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Kindell & Hoppe
(b) Address 312 S Highland Ave

19 (a) (Date rec'd by registrar) (b) E. L. Williams Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1945 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1945 to 5/20 1945, and that I last saw h. alive on 5/19 1945.

Immediate cause of death	Duration
Cardio-Resp Failure	
Due to Pneumonia of	?
Lower Lobe	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl H. Paterson M.D.
Address Mercy Hosp Date signed 5/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

629169 Registered No. 2688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore city (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (No) (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ida Strickland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Sylvester Strickland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1894

8. AGE: Years	Months	Days	If less than one day
51	4	2	hr. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business House work

FATHER
12. Name John Snowden
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Jeanette Queen
15. Birthplace Annapolis Md

16 (a) Informant Mr. Wilbur Strickland
(b) Address 1717 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, B.C.Co.

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 332 N. Belnord Ave

19 (a) (Date received by Registrar) MAY 24 1945 (Registrar) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21-1945 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-1944 to 5-21-1945 and that I last saw her alive on 5-20-1945

Immediate cause of death Carcinoma of rt. kidney — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 5-24-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 5700

G29170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G29170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or Institution St. Josephs Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Dame
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4708 Blueridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Paul Mc Guire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 45

8. AGE: Years	Months	Days	If less than one day
			23 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul C. Mc Guire
13. Birthplace Pa

MOTHER
14. Maiden Name Mollie Kaye
15. Birthplace Kansas

16 (a) Informant Mrs. Paul C. Mc Guire
(b) Address 4708 Bluerdge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director R. J. Rush
(b) Address 536 N. Howard

19 (a) MAY 24 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945 to May 23 1945 and that I last saw him alive on May 23 1945

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions Prematurity 7 mo 3 lbs 1 1/2 oz
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A M Bacon Jr M. D.
Address St Josephs Hospital Date signed 5-23-45

VS 150

G29171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G29171

A B -93573

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Von Bonn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1879 ? ~~July 27-1878~~ ?

8. AGE: Years	Months	Days	If less than one day
65 ? ~~66~~ ?	9	15	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Von Bonn (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Axt (D)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 24 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 24 1945 Thomas Jon Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1945 to 5-12 1945, and that I last saw h 1 alive on 5-12 1945.

Immediate cause of death Cerebral thrombosis — Duration 12 hrs

Due to Cerebral arteriosclerosis

Due to

Other Conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 5-22-45

2722

X

G29172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1492

G29172 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John St.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Severn (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice Emily Freedenberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Jacob Freedenberg
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) August 14, 1884

8. AGE: Years	Months	Days	If less than one day
60	9	10	hr. min.

9. Birthplace Conestoga, Pennsylvania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Andrew S. Graver
13. Birthplace Conestoga, Pa.

MOTHER
14. Maiden Name Emily Ketley
15. Birthplace Conestoga, Pa.

16 (a) Informant Mr. Jacob Freedenberg
(b) Address Severn Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director Wilkinson Lamoreaux
(b) Address 1003 W. Baltimore St.

19 MAY 24 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1945, at 8:53 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 20, 1945, to May 24 1945, and that I last saw h.e.r. alive on May 24, 1945.

Immediate cause of death Carcinomatosis, generalized — Duration

Due to Carcinoma of Vulva

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. T. Wine M. D.
Address Hospital for Women of Md. Date signed 5/24/45

X

629173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

629173 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WBGH (West Balto. Gen. Hosp)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Condelia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nellie E. Boyd.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-2741

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed ~~Married~~

6 (b) Name of husband or wife: William F. Boyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 19, 1877 6-19-77

8. AGE: Years 67 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation ~~House wife~~ Grand Secretary

11. Industry or business Eastern Star

FATHER
12. Name John Wesley Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriett R. Smith
15. Birthplace Oella, Md.

16 (a) Informant Mr. William Lee Boyd
(b) Address 3203 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilbur Lamond
(b) Address 4510 Liberty Heights Ave.

19 (a) MAY 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22- 1945 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14- 1945 to 5-22- 1945, and that I last saw her alive on 5-22- 1945.

Immediate cause of death: Respiratory Failure — Duration:

Due to Carcinoma of Cervix with Bowels Bladder involvement.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alberto Adams M.D.
Address West Balt. Gen. Hosp. Date signed 5/24/45

Alberto K. Adams

G29174

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29174

CERTIFICATE OF DEATH

131B

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 E. Madison St., 6 Ward)

Length of residence in city or town where death occurred ...yrs. ...mos. ...da. How long in U. S. If of foreign birth? ...yrs. ...mos. ...da.

If U. S. Veteran specify WAR .....

2. FULL NAME Edward Johnson

(a) Residence: No. 1515 E. Madison St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Col	W.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Johnson

6. DATE OF BIRTH (month, day, year) Jan. 16, 1862

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
83	4	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Evelyn Butcher
(Address) 1515 E. Mad St

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Cem Date May 25 1945

19. UNDERTAKER Robert L Williams
(Address) 835 Mc Elderry St

20. FILED MAY 29 1945, 19.....
Registrar.

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 5-22, 1945

22. I HEREBY CERTIFY, That I attended deceased from 5-19, 1945 to 5-22, 1945

I last saw h[illegible] alive on 5/20 1945. Death is said to have occurred on the date stated above, at 1 [illegible] p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	2 yrs
Other contributory causes of importance: Chronic Nephritis	2 yrs?

Was an operation performed? No Date of .....

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury ....., 19.....

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) Carlton B. LeCompte M. D.

(Address) 1103 N. Caroline St

X

VS 3

THIS IS A PERMANENT RECORD. Entries must be made with PEN AND INK—PENCIL WRITING WILL NOT PHOTOGRAPH. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 R

Registered No. 629175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminister
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Rosalie Fletcher

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Col.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 9, 1941

8. AGE: Years	Months	Days	If less than one day
3	11	15	—hr. —min.

9. Birthplace New Windsor, Md.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name Clinton Fletcher
13. Birthplace Robville, Md.

MOTHER
14. Maiden Name Elsie Squirrell
15. Birthplace Westminster, Md.

16 (a) Informant Clinton + Elsie Fletcher
(b) Address Westminister, Md.

17 (a) Burial (b) Date thereof May 27-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Chapel
Location New Windsor Md

18 (a) Funeral director D. D. Fuller & Son
(b) Address Main Bridge & New Windsor Md

19 MAY 25 1945 Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 1945 to 5/24 1945 and that I last saw her alive on 5/24 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Meningitis	14 days
Due to Tubercle bacillus	
Other Conditions miliary tuberculosis tuberculous osteomyelitis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hospital Date signed 5-24

G29176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G29176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 E. Eager St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIETTE NOVOTNY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	White	Married

6 (b) Name of husband or wife Joseph Novotny
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 29, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	25	..... hr. ..... min.

9. Birthplace Czeckoslovania (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Anton Donberg
13. Birthplace Nucho Slovacka

MOTHER
14. Maiden Name Anna Peko
15. Birthplace Czechlovska

16 (a) Informant Jos Novotny
(b) Address 2312 E Eager St

17 (a) Oak Hill (b) Date thereof May 27 '45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem
Location City

18 (a) Funeral director Wilbert Funeral Home
(b) Address 2208 Eutaw Pl

MAY 25 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION M

20. DATE OF DEATH May 24, 1945, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21, 1945, to May 24, 1945, and that I last saw her alive on May 23, 1945.

Immediate cause of death	Duration
Acute dilitation of heart	2 days
Due to Advanced arterio-sclerosis & hypertension ??	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans S. Wilbert M. D.
Address 3220 Fairmount Ave Date signed May 24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G29177
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 E Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella L Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm Wilson
6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Sept 5 1858

8. AGE: Years 86 | Months 8 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Dont Know
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Balto

16 (a) Informant Mrs Elizabeth Sommers
(b) Address 2738 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director Elliott Funeral Home
(b) Address 2005 Eutaw Pl

19 (a) MAY 25 1945 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 2 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to May 22 1945, and that I last saw h[illegible] alive on May 22 1945

Immediate cause of death
Diabetic Coma — Duration 5/19/45

Due to Diabetes Mellitus — 1/1944

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Ryan M. D.
Address 601 E Lanvale St Date signed

VS 150

G29178 MARQUETTE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G29178

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 E 30th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 E 30th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Marquette

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1864

8. AGE: Years 80 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John A Marquette
13. Birthplace Md

MOTHER 14. Maiden Name Gonzalo C Leonard
15. Birthplace Baltimore Md

16 (a) Informant James A Marquette
(b) Address 803 Uncle Tom

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/25/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Conde
(b) Address 1217 E Pratt St

19 (a) MAY 25 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22, 1942 to May 23, 1945, and that I last saw her alive on May 22, 1945.

Immediate cause of death	Duration
Coronary Occlusion	3 yrs.
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L Reamer M.D.
Address 514 Armory Pl Date signed 5/22/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G29179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home 11-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d
(e) Length of stay in Baltimore (yrs., mos., or days) 4y 4m Sovereign

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Rumsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1900

8. AGE: Years	Months	Days	If less than one day
4 4	4	29	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Dr. C. L. Rumsey
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Wailes
15. Birthplace Maryland (?)

16 (a) Informant C. L. Rumsey
(b) Address 812 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry McKenrick & Son
(b) Address 847 Cathedral

19 (a) (Date received by registrar) MAY 29 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1945 to May 24 1945 and that I last saw her alive on May 24 1945

Immediate cause of death acute hepatitis of undetermined etiology — Duration 3 weeks

Due to —

Due to —

Other Conditions Pyelonephritis, acute, right

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Marvin N. Davis M. D.

Address Church Home Date signed 5-24-45

125R

G29180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G29180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 14
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 770 Vine St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HOLLOWAY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Robert Holloway
6 (c) If alive, give age 8 years

7. Birth date of deceased November 13 1903

8. AGE: Years	Months	Days	If less than one day
41 42	6 -	13 -	hr. min.

9. Birthplace Florida (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Patient.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City
18 (a) Funeral director Joseph A. Lively
(b) Address 4 N. Gilmor Street.
19 (a) MAY 25 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23 1945 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1945 to 5-22 1945 and that I last saw h~~e~~r alive on 5-23 1945

Immediate cause of death Intestinal Obstr.
Fibroids, uterine.
~~Due to~~ Carcinoma, ascending colon?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 yr.

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Carl Ebeling III M. D.
Address Univ. Hosp. Date signed 5-23-45

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

629181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Vincent Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Vincent Av (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hester Dorsey
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) ? 1915

8. AGE: Years 30 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Moses Dorsey
13. Birthplace Md.

MOTHER 14. Maiden Name Louche Davis
15. Birthplace Md.

16 (a) Informant Hester Dorsey
(b) Address 1027 Vincent Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory
Location Reynolds Town Md

18 (a) Funeral director Chas N. Alexander
(b) Address 922 N. Mount St.

19 (a) MAY 25 1945 (Date received by local registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to May 24 1945, and that I last saw him alive on Jan 15 1945.

Immediate cause of death Pulmonary Hemorrhage — Duration 1 day

Due to Tuberculosis of Lungs — Duration 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. William Frey M. D.
Address 928 Pa. Ave Date signed 5/26/45

629182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 56E

629182

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp. J-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Dallas St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Katie Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			....hr. ....min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Edmund Bernard
13. Birthplace Va
MOTHER 14. Maiden Name Sarah Bernard
15. Birthplace Va
16 (a) Informant Mary Francenbaugh
(b) Address 905 N. Dallas St.
17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.G. County
18 (a) Funeral director Lester Bros.
(b) Address 1408 Ashland ave.
19 (a) MAY 25 1945 (b) Huntington Williams, M.D.
(Date rec'd by Reg'r War) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23rd 1945, at 5-45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon, and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Papilloma of Larynx

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Gaither M.D.
Medical Examiner.
Date signed May 23 1945

629183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

629183 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 No. Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Catherine S Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1872

8. AGE: Years 69 | Months 5 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name GEORGE ROBERTS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name CATHERINE O'BRIEN
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. ALICE REINEL
(b) Address 3330 ELMLEY AVENUE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location.....

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 413 W. Mt. Royal Ave.

19 (a) MAY 25 1943 (Date rec'd by registrar) at Washington Hollow, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20/1945, to 5/23/1945, and that I last saw her alive on 5/23/1945.

Immediate cause of death Intentional obstruction

Duration

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Charles E. Shaw Jr. M.D.
Address Md. Gen. Hosp. Date signed 5/25/45 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29184

BALTIMORE CITY HEALTH DEPARTMENT ✓ G29184

CERTIFICATE OF DEATH 47C Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Loyola

(c) Hospital or institution: South Bal. Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 S. Montford Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary A. Dzygo

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife — Michael

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 29, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	23	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Cieznick

13. Birthplace Poland

MOTHER 14. Maiden Name Michalena Jaroszy

15. Birthplace Poland

16 (a) Informant Frank Surv. Next

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. F. Sodomski & Son

(b) Address 1808 Eastern Ave.

19 (a) MAY 25 1945 (b)

(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1945 to May 22 1945 and that I last saw her alive on 5/22 1945.

Immediate cause of death Bronchogenic Carcinoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John Malcolm Bloxom M. D.

Address South B. Gen Hosp Date signed 5/24/45

Huntington Williams, M.D.

X DR. BLOXOM

629185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 629185

JO #91805

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1417 Barnes St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1883

8. AGE: Years 61 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name George Fisher

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary E. Hebrons

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location A. A. County, Md.

18 (a) Funeral director Joseph B. Lorks, Jr.

(b) Address 4145 N. Central Ave

19 (a) MAY 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25, 1945, to May 23, 1945, and that I last saw him alive on May 23, 1945.

Immediate cause of death Bronchial - Pneumonia — Duration 6 days

Due to

Due to

Other Conditions Bronchi - Pneumonia (Include pregnancy within 3 months of death) — Duration 3 days

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. M. Phillips

Address Balt City Hosp Date signed May 23 1945

VS 150

G29186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G29186 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Thorpe Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby boy Douglas Dinsdale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Jonnie Douglas

15. Birthplace

16 (a) Informant Hosp Record

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 25 1945

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 25 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945, to 19; and that I last saw h alive on 19.

Immediate cause of death: Subarachnoid Hemorrhage — Duration 10 days

Due to Ruptured aneurism

Due to

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Mason M. D.

Address Mahoney Date signed 5-25

VS 150

2725 X

G29187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G29187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Washington
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Theresa Ryjacek
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 28, 1891
8. AGE: Years 53 54 | Months 10 | Days 25 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Johns Hopkins Hospital

FATHER
12. Name Joseph Ryjacek (d)
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Trestik (d)
15. Birthplace Czechoslovakia

16 (a) Informant Frances Ryjacek (sister)
(b) Address 831 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ Holy Redeemer Cemetery
Location Belair Rd. Balto. Md.
18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street
(c) MAY 25 1945 (Date received by Registrar) (b) Registrar

Washington Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 8:00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945 to May 23 1945 and that I last saw h[illegible] alive on May 23 1945
Immediate cause of death: Cerebral hemorrhage — Duration
Due to: Hypertensive cardio-vascular disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 5/26/45

X

629188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. 629188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Ashland Ave
(c) Hospital or institution: ....
(d) Length of stay in hospital or inst. (yrs., mos., or days) ....
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Ashland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ....

3 (a) FULL NAME Bernard Anthony Garrits

3 (b) If veteran, name war ....

3 (c) Social Security Account No. ....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Stella (nee Hladky)
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	7	... hr. ... min.

9. Birthplace Holland (Town, county, and state)
10. Usual Occupation Foreman Plumber
11. Industry or business American Brewery

FATHER
12. Name John Garrits
13. Birthplace Holland

MOTHER
14. Maiden Name Alida Deruyger
15. Birthplace Holland

16 (a) Informant Stella Garrits
(b) Address 2834 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) MAY 25 1945 (Date rec'd by Registrar) (b) ... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to ....

Other Conditions Mental Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 24 1945 2 P.M.
(b) Where did injury occur? 2834 Ashland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged self

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 24 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629189 ✓ 629189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 Carswell St
(c) Hospital or institution: at home yes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltotity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Carswell St (If rural give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Henry Miller Sr. ✓

3 (b) If veteran, name war none

3 (c) Social Security Account No. 214-03-1018 ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Miller

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 20 1876

8. AGE: Years 69 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Charles Henry Miller
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Isabella Briscoe
15. Birthplace Balto. Md.

16 (a) Informant Mrs Anna Miller (wife)
(b) Address 1427 Carswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26 41 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Sherwin Mann Co.
(b) Address 108 W North Ave.

19 (a) MAY 25 1945 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 12 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945 to May 22 1945 and that I last saw h. l. alive on May 22 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 1 wk
Due to: Arteriosclerosis — Duration ?
Due to: — Duration —
Other Conditions: Central nervous system Syphilis — Duration ?
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Harrell Pearce M. D.
Address 312 med. arts Bldg Date signed 5/25/45
Baltimore, Md

VS 150

83a

G29190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G29190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1912 McKean Ave.

(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. 4

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1912 McKean Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME BARBARA CHEW

3 (b) If veteran, name war	3 (c) Social Security Account No.
None --	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife William B. Chew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1867

8. AGE: Years	Months	Days	If less than one day
78	3	21	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Anthony Ruppel

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Schmidt

15. Birthplace Germany

16 (a) Informant Mr. William Chew

(b) Address 1800 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

MAY 25 1945

19 (a) Huntington Williams, M.D. (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to May 23 1945

and that I last saw h-- alive on May 23 1945

Immediate cause of death	Duration
Due to ~~Diabetes~~	
Due to Diabetes Mellitus	20 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. S. Tenny M.D.

Address 607 N. Howard St. Date signed 5/25/45

VS 150

Wm. J. Tickner X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

629191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5731 Govane Ave.
(c) Hospital or institution:

5718

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5731 Govane Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA MARY BENNETT

3 (b) If veteran, name war: -

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife David L. Bennett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1878

8. AGE: Years	Months	Days	If less than one day
66	5	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Haupt
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude -
15. Birthplace Germany

16 (a) Informant Mr. David L. Bennett
(b) Address 5731 Govans Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 25 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945, to My 23 1945 and that I last saw h her alive on My 23 1945.

Immediate cause of death	Duration
Carcinoma of Liver	1942
Carcinoma of Uterus	1944
Due to	
Due to	
Other Conditions - Tetanus	1945

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. W. Bishop M. D.
Address 51-53 Shinder Date signed My 24

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G29192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs. or less
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore # 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5108 Whiteford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lavinia augusta Mead

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Ellsworth T. Mead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6 1886

8. AGE: Years	Months	Days	If less than one day
59	1	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward E. Teale
13. Birthplace New York

MOTHER
14. Maiden Name Melina O. Looker
15. Birthplace New York (Brooklyn)

16 (a) Informant Mr. Ellsworth T. Mead
(b) Address 5108 Whiteford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 23 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1945 to May 24 1945; and that I last saw h[illegible] alive on May 24 1945.

Immediate cause of death	Duration
Embolism	
Due to Diabetic Coma	
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Fine nodular thickening of colon above [illegible]
of autopsy: Emphysema [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 5/24/45

G29193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G29193 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1736 Poplar Grove St.

(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1736 Poplar Grove St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK S. BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	220-05-4050

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Tillie Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	22	hr. min.

9. Birthplace Elmira, N. Y.
(Town, county, and state)

10. Usual Occupation Tavern Keeper

11. Industry or business

FATHER
12. Name Charles Brown
13. Birthplace N. Y.

MOTHER
14. Maiden Name Rebecca Colston
15. Birthplace N. Y.

16 (a) Informant Mrs. Vallie Brown
(b) Address 1736 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 25 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1945, at 6:15AM

21. I certify that death occurred on the date above stated: that I attended deceased from May 16 1945, to May 24 1945, and that I last saw h... alive on 19...

Immediate cause of death Chronic carcinoma — Duration 8

Due to disease

Due to

Other Conditions Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Ernest Lahr

Address 173 Poplar Gr St Date signed 5/26/45

VS 150

X

G29194 Weber

BALTIMORE CITY HEALTH DEPARTMENT ✓ G29194

CERTIFICATE OF DEATH 92B

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Weber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1861

8. AGE: Years 83 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Smith
13. Birthplace Germany

MOTHER 14. Maiden Name Christiana ?
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 914 Greenmount Ave

19 (a) 5/25/1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 24 1945, and that I last saw her alive on May 23 1945.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Chr Myocarditis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E North Ave Date signed 5/24/45

Huntington Williams, M.D.

G29195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G29195 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6 - 1875

8. AGE: Years	Months	Days	If less than one day
70	2.	18	hr. min.

9. Birthplace Edinberg. Va.
(Town, county, and state)

10. Usual Occupation House Keeper

11. Industry or business

FATHER
12. Name George J. Cooper.
13. Birthplace Edinburg Va.

MOTHER
14. Maiden Name Drusilla Dawkins
15. Birthplace Edinburg Va.

16 (a) Informant Miss. Nellie Cooper.
(b) Address 3023 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26/1945 (month) (day) (year)
(c) Cemetery or crematory Cedarwood Cemetery
Location Edinburg Va.

18 (a) Funeral director Francis G. Lefer
(b) Address 1600 W. North Ave Baltimore, Md.

19 (a) MAY 26 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24/ 1945; at 6-12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31/ 1944 to 5/24/ 1945; and that I last saw her alive on 5/23/ 1945.

Immediate cause of death Cardio - vascular -

Duration Final 8/31/44

Due to renal disease -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jessie A. Bowden
Address 1512 E. North Ave Balto 13 Md Date signed 5/24/45

X

G29196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

G29196 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4618 Kavon Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Kavon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Elizabeth Huff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Benjamin L. Huff
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) 11/22/1869

8. AGE: Years	Months	Days	If less than one day
75	6	2	hr. min.

9. Birthplace Hampshire County, West Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eli Bell Nixon
13. Birthplace West Virginia

MOTHER
14. Maiden Name Alenida Bohrer
15. Birthplace West Virginia

16 (a) Informant Mrs. George Baker
(b) Address 4616 Kavon avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 '45 (month) (day) (year)
(c) Cemetery or crematory Hillcrest Cemetery
Location Lansdowne, Maryland

18 (a) Funeral director Frederick D. Matthews
(b) Address 3019 E. Monument Street

19 (a) NOV 26 1945 (Date filed in Bureau) Practice for Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 45, at 12:21 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 45 to May 25 19 45, and that I last saw him alive on May 22 19 45.

Immediate cause of death Ch. Myocarditis
Due to Arteriosclerosis
Due to Ch. Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Duration 6 years.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Harding, M.D.
Address 4810 Belair Rd Date signed 5/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1318 Registered No. G29197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 N Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sylvester Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Della

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3. 1879

8. AGE: Years 65 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business R & R

FATHER 12. Name James Gregory

13. Birthplace Ga.

MOTHER 14. Maiden Name Mary

15. Birthplace Ga

16 (a) Informant Mrs Melvin Fisher

(b) Address 600 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director Wilson Lee Lee

(b) Address 1217 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAY 26 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to May 24 1945, and that I last saw him alive on May 24 1945.

Immediate cause of death Acute Myocarditis and Nephritis & Anuria

Due to Chronic Myocarditis and Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Yrs 4 Mos unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M.D.

Address 609 W North Ave Date signed 5/25/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

629193

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... Ave
(c) Hospital or institution: Union Memorial Hosp. 145
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No.
If yes, name country

3 (a) FULL NAME James McDonnell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. J E McDonnell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 4 1882.

8. AGE: Years 62 | Months 8 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John J. McDonnell
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Alice B Snyder
15. Birthplace Balto Md.

16 (a) Informant Mrs. J E McDonnell
(b) Address 1402 Linden Ave

17 (a) Burial (b) Date thereof 5-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Catholic
Location Baltimore Md

18 (a) Funeral director Wilson Conroe
(b) Address 1217 E Fayette St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 26 1945

vs 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1945, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1942, to 5-25 1945, and that I last saw him alive on 5-25 1945.

Immediate cause of death C-R failure

Due to coronary occlusion

Due to Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address U M H. Balto. Date signed 5-28-45

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

629199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 629199

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen Nellie Donohoe

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4196

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug about 1893

8. AGE: Years	Months	Days	If less than one day
about 51	9		hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business Dr. Hamburger

FATHER
12. Name Edward Donohoe
13. Birthplace Ireland

MOTHER
14. Maiden Name Delia Roach
15. Birthplace Ireland

16 (a) Informant Dr. Hamburger
(b) Address 1207 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) MAY 26 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1936 to May 24 1945, and that I last saw h. alive on May 24 1945

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to: Arteriosclerosis (cerebral)
Due to: Arterial hypertension — 10 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M.D.
Address 1207 Eutaw Pl Date signed V-25-45

VS 150

G29200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G29200 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 N. Howard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis J. Derlin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 12th 1909

8. AGE: Years 36 | Months 1 | Days 12 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dr Jacob W. Derlin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Josephine Zimmerman
15. Birthplace Balto. Md.

16 (a) Informant Dr. J.W. Derlin
(b) Address 811 N. Howard St.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 5/28/45 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Herbert F. Williams M.D.

MAY 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24th 1945, at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to May 24 1945.
and that I last saw h alive on 5-24 1945

Immediate cause of death: Pneumonia — Duration

Due to: Ideocy — Congenital Cretin. — past

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard J. Cohen M. D.
Address Marlboro, Md. Date signed 5/26/45

X

G29201 ORRIN J. EYLER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29201 2012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Street
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rear of 5302 Ethelbert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Orrin Joshua Eyler

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1873

8. AGE: Years 71 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Eyler
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Lucretia Ott
15. Birthplace Frederick Co. Md.

16 (a) Informant Luther M. Johnson
(b) Address 3349 Belvedere Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) Removal for (b) Date thereof May 26 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cemetery
Location Hanover, PA

18 (a) Funeral director F. M. Little & Son
(b) Address Littlestown, PA Pa R.F.D.

19 (a) MAY 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23- 1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Unable to determine

Due to

Other Conditions Autopsy changes in all cavities & organs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 5-24-45

VS 151

BETZ. G29202

G29202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 157 N. Dukes. Ct.
(c) Hospital or institution: h

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 157 N. Dukes Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Betz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Henry Betz
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31 1870

8. AGE: Years 74 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Hannas Run Balto. Co.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Jacob Cuzh
13. Birthplace North Carolina

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Ruth B. Miller
(b) Address 84 Dundalk Ave.

17 (a) Burial (b) Date thereof May 28-45
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Road

18 (a) Funeral director John A. Ingram
(b) Address 3000 E. Balto. St.

19 (a) MAY 26 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24th 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1945 to 5/24 1945 and that I last saw h[illegible] alive on 5/24 1945.

Immediate cause of death: Hypertension cardiovascular renal disease — Duration 2

Due to

Due to

Other Conditions Uraemia. — 4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Sokoloff M. D.
Address 5939 Dr. Ellerslie Date signed 5/25/45

VS 150

Huntington Williams, M.D.

629203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. 629203

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Dundalk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michalina ~~Mary~~ Ellert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ignatius Ellert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 28 1880

8. AGE: Years 64 Months 7 Days 26 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wladyslaw Bromny

13. Birthplace Poland

MOTHER 14. Maiden Name Albina Wanieski

15. Birthplace Poland

16 (a) Informant Mrs Chas Ellert

(b) Address 1005 Dundalk ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 28 45 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus Cem

Location Balto City

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester St

19 (a) (Date received by Local Registrar) MAY 29 1945 Huntington P. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1941 to May 24 1945.
and that I last saw he alive on May 24 1945

Immediate cause of death Acute Cardiac Dilatation — Duration 1 day

Due to Chronic Myocarditis — 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Zgonbich M. D.

Address 1802 Eastern Ave Date signed 5-25-45

X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G29204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 696 Pierce
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 696 Pierce (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Florence Kay Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	—

6 (b) Name of husband or wife Eugene Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1896

8. AGE: Years	Months	Days	If less than one day
48 49	7	18	hr. min.

9. Birthplace Warsaw, Virginia (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER 12. Name Sorrell.
FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name
MOTHER 15. Birthplace

16 (a) Informant Mrs. Eugene Watkins
(b) Address 696 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 26 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945 to May 23 1945, and that I last saw h[illegible] alive on May 23 1945.

Immediate cause of death	Duration
Myocarditis	7 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address [illegible] Date signed 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29205 Registered No. 1117a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 857 W. Lexington

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 857 W Lexington (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Nolley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida Nolley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1882

8. AGE: Years 63 Months — Days — If less than one day hr. min.

9. Birthplace Dunnsville Co Va (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name John Nolley

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name

MOTHER 15. Birthplace Va

16 (a) Informant Mrs. Ida Nolley

(b) Address 857 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-26-'45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 1122 N. Schroeder St

19 (a) MAY 26 1945 (Date Filed by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1945, to 5/23 1945. and that I last saw him alive on 5/23 1945.

Immediate cause of death Hypertension

Curlis Nephritis

Due to

Due to

Other Conditions Fight the Week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Svaunder M. D.

Address 1224 Seeds Date signed 937 5/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

629206 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: Univ Hospital 18+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Branch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Color | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife Lee Branch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 12 - 1900

8. AGE: Years 45 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Chester, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Geo. Rucker

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Allen

15. Birthplace Va.

16 (a) Informant Lee Branch

(b) Address 209 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5, 26, '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Hattie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by Registrar) MAY 26 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 23 1945 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 3 1945 to 5 - 23 1945 and that I last saw her alive on 5 - 23 1945

Immediate cause of death Uremia — Duration

Due to CA of cervix + metastasis (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4 - 12 - 45

Major findings of operation: CA of cervix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Simmons M. D.

Address Univ. Hosp. Date signed 5 - 24

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

G29207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29207

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 S. Augusta Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S. Augusta Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA MALONE SPURRIER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Walter David Spurr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	29	hr. min.

9. Birthplace Ellicott City, Howard Co. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Emmett Malone
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Fitzpatrick
15. Birthplace Ireland

16 (a) Informant Miss Rita Spurrier
(b) Address 324 S. Augusta Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Maryland

MAY 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1945 19 6.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1945 to 5/24 1945.
and that I last saw h[illegible] alive on 5/22 1945.

Immediate cause of death	Duration
Coronary Thrombosis	3 hrs
Due to Cardio Vascular Disease & Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M.D.
Address 343 S. Fremont Ave Date signed 5/25/45

G29208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G29208 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 E. Pratt St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Michael Amato
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	WHITE	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	6	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Store keeper
11. Industry or business

FATHER
12. Name Salvatory Amato
13. Birthplace Italy

MOTHER
14. Maiden Name Clara Fuhes
15. Birthplace Italy

16 (a) Informant Chiara Shott (Daughter)
(b) Address 3712 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director Fraulo Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md

MAY 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1945 to 5/24 1945 and that I last saw him alive on 5/24 1945

Immediate cause of death Cardiac decompensation — Duration

Due to Chronic asthmatic bronchitis

Due to

Other Conditions Ruptured appendix peritonitis
(Include pregnancy within 3 months of death)

Date of operation 5/22/45

Major findings of operation: Ruptured appendix, peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Herold M. D.
Address Md. Gen. Hosp. Date signed 5/24/45

X

G29209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G29209 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N. Carey St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick A. Booker Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1910

8. AGE: Years 34 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick A. Booker
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emma Parks
15. Birthplace Baltimore Md.

16 (a) Informant Frederick A. Booker
(b) Address 1902 [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1945, at 1:31 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/20 1945 to 5/25 1945.
and that I last saw h alive on 5/24 1945

Immediate cause of death

(a) Acute Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of examination

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Clyde Cowan M. D.
Address 1131 Harlem Date signed 5/27/45

VS 150

MAY 26 1945 Huntington Williams, M.D.

JO 783775 G29210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G29210 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs. 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: John Henry Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife: Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1872

8. AGE: Years	Months	Days	If less than one day
72	-8-	-8-	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mittie ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Q 9 County

18 (a) Funeral director Mrs Kifer & Edwards
(b) Address 1129 N. Carlines St

19 (a) (b) Registrar
MAY 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23, 1945, to May 23, 1945, and that I last saw h. im alive on May 23, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	4 hrs.
Due to Hypertensive arteriosclerotic heart disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. M. Phillipp
Address Baltimore Date signed May 27 1945

X

G29211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G29211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Brightwood Ave.
(c) Hospital or institution:
28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Brightwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOHN DAVIS PARKER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha M. Parker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 18, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	5	hr. min.

9. Birthplace: Dorchester Co., Md.
(Town, county, and state)

10. Usual Occupation: Chief Clerk

11. Industry or business: Balto. Transit Co.

FATHER
12. Name: Johanas Parker
13. Birthplace: Dorchester Co., Md.

MOTHER
14. Maiden Name: --
15. Birthplace

16 (a) Informant: Mrs. Bertha M. Parker
(b) Address: 3207 Brightwood Ave. 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by Registrar: MAY 26 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to May 23 1945 and that I last saw h[illegible] alive on May 21 1945

Immediate cause of death: Carcinoma of Pancreas — Duration 1-7 mo

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature W. N. Kremper M. D.
Address 1428 Hampden Pl. Date signed 5-26-45

G29212
46-93774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G29212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefull supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius Serio

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27- 1904

8. AGE: Years 40 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Serio
13. Birthplace Italy

MOTHER
14. Maiden Name Prudence Liburto
15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Mendell & Lippold
(b) Address 312 S. Hartford Ave

19 (a) MAY 26 1945 (Date received by local registrar) (b) Huntingtor Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24- 1945, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23- 1945, to 5-24 1945, and that I last saw h. in alive on 5-24- 1945.

Immediate cause of death	Duration
Terminal Cardiac failure	2
Due to	
Due to Fatty Liver + alcoholism hepatitis	13 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 5-25-45

X

G29213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G29213 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home 2 wks

(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County City

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 813 N. Bentalou

(If rural give location)

(e) Citizen of foreign country? - (Yes or No)

If yes, name country -

3 (a) FULL NAME John Criswell

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-3601

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Dorothy Criswell - deceased.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14-1873

8. AGE: Years 71 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Rigger

FATHER

12. Name Francis Criswell

13. Birthplace Carroll Co. Md

MOTHER

14. Maiden Name Louisa Conaway

15. Birthplace Carroll Co. Md

16 (a) Informant P. C. Hansen

(b) Address 813 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27-45 (month) (day) (year)

(c) Cemetery or crematory Oaklawn

Location Eastern Ave

18 (a) Funeral director Frank H. Purnell

(b) Address Pikesville, Maryland

(Filed by registrar) Huntington Williams (Registrar)

MAY 27 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945 at 6 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to May 24 1945, and that I last saw him alive on May 22 1945.

Immediate cause of death: cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. H. Cutterman M. D.

Address 2324 Resistertown Rd Date signed 5/26/45

X

G29214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G29214 Registered No. (area)

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, ~~Maryland~~

(b) Street address ~~Harford Co~~

(c) Hospital or institution Univ. Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County Harford

(c) City or town DARLINGTON MD. (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ernest Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	5	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Mill operator

11. Industry or business FLOUR

FATHER 12. Name George

13. Birthplace Md

MOTHER 14. Maiden Name Georgiette Bael

15. Birthplace Md

16 (a) Informant Margaret R Hopkins

(b) Address Same address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 29 45 (month) (day) (year)

(c) Cemetery or crematory Darlington

Location Harford

18 (a) Funeral director H. S. Bailey

(b) Address Darlington Md

19 (a) ~~MAY 29 1945~~ (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945, to May 25 1945, and that I last saw him alive on May 25 1945

Immediate cause of death Uremia — Duration 3 wks

Due to Hypertensive C.V.D. 2 yrs — Duration —

arteriosclerosis + arteriosclerotic kidney

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles G. Chapin

Address Univ. Hospital Date signed 5/26/45 M. D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G29215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 Forman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Forman Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Saalbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles Saalbach

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1851

8. AGE: Years 93 | Months 9 | Days 23 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Elizabeth Freiburger

(b) Address 22 Forman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director George H. Schwab

(b) Address 2101 Frederick Avenue

19 (a) MAY 27 1945 (Received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1930 to May 5 1945, and that I last saw h. Ealive on May 4 19 45

Immediate cause of death: Myocarditis — Duration 2 wks

Due to: Cerebral Arteriosclerosis — 10 yrs

Due to: Coma

Other Conditions: Chronic Bronchitis, Senility — 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature Howard Kahn M. D.

Address 7027 West St Date signed 5/28/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29216 BALTIMORE CITY HEALTH DEPARTMENT ✓ G29216

CERTIFICATE OF DEATH 518 Registered No.

JO #95184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Dillon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Jett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Alice (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1870

8. AGE: Years	Months	Days	If less than one day
74	-8-	-2-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Jett (d)
13. Birthplace ?

MOTHER
14. Maiden Name Lucy ? (d)
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/45 (month) (day) (year)
(c) Cemetery or crematory
Location Remington, Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) 1945 Filed by registrar [illegible] for William [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 18, 1945 to May 23, 1945, and that I last saw h in alive on May 23, 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	10 hrs
Arteriosclerotic Heart Disease	7
Due to Uremia	7
Due to	
Other Conditions Carcinoma of Prostate Bilateral Pyonephrosis	

(Include pregnancy within 3 months of death)

Date of operation 5-11-45
Major findings of operation: Carcinoma of Prostate
of autopsy: Hypostatic Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Penny M.D.
Address Baltimore City Hosp. Date signed 5/25/45

VS 150

G29217 ✓ G29217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3122 Woodland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 57

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3122 Woodland Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jennie Cohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER

12. Name Samuel Cohn

13. Birthplace Russia

MOTHER

14. Maiden Name Rachael Cohn

15. Birthplace Russia

16 (a) Informant Harry S. Cohn

(b) Address 4912 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1945 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men Cem

Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

MAY 27 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 44 to May 26 1945, and that I last saw h[illegible] alive on May 23 19 45

Immediate cause of death: Metastatic tumors of bone Duration 8 mos

Due to: Carcinoma of breast

Due to: Arteriosclerosis (Contributing)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos J Abbott M. D.

Address 451 S Liberty Hwy Date signed 5-26-45

VS 150

— 8 —

G29218 ✓ G29218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4303 Arabia Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4303 Arabia Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bertha A. L. Behrens

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: August H. Behrens

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Sept 5. 1880

8. AGE: Years 64 | Months 8 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Adolphus H. Weaver

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Emma Schipperling

15. Birthplace Baltimore Md

16 (a) Informant August H. Behrens

(b) Address 4303 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28. 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director Jas. Wm. John W. Teufel & Son

(b) Address 801 W. Fayette St

MAY 27 1945 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 10 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1944 to May 24 1945 and that I last saw her alive on May 24 1945.

Immediate cause of death Coronary obclusion — Duration 4 hrs

Due to Thrombophlebitis

Due to

Other Conditions Coronarysclerosis Chr. Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. V. Harbold M. D.

Address 4706 Harford Road Date signed 5/26/45

X

G29219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29219

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2:0:0
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Barclay St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles A. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1897

8. AGE: Years	Months	Days	If less than one day
47	8	14	...hr. ...min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business News-Post Paper

FATHER
12. Name Jacob S. Smith
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Florida Zebeckels
15. Birthplace Baltimore, Md.

16 (a) Informant Herbert Smith
(b) Address 1610 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul Street

19 (a)..... (b)..... (Date received) (Registrar)
MAY 27 1945 Huntington Hilleary M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....

Coronary Occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mudd M.D. Medical Examiner.
Date signed 5-26-45

G29220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G29220

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5506 Hampstead Ave,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Talbot

(c) ~~City or~~ town Neavitt, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Jane Jones

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Thomas Alfred Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1861

8. AGE: Years	Months	Days	If less than one day
83	6	19	hr. min.

9. Birthplace Neavitt, Md
(Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER 12. Name Wm Jones

13. Birthplace Neavitt, Md

MOTHER 14. Maiden Name Emily Lawrence

15. Birthplace Neavitt, Md.

16 (a) Informant Mrs Earl W. Parlett

(b) Address 5506 Hampstead ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29/45 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Neavitt, Md

Location

18 (a) Funeral director John O. Mitchell Sons & Co

(b) Address 1900 Eutaw Place.

19 (a) MAY 27 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945, to May 26 1945, and that I last saw h~~e~~ alive on May 25 1945

Immediate cause of death Cerebral Hemorrhage (Apoplexy) Duration May 22 1945

Due to

Due to

Other Conditions Arteriosclerosis a number of years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas B. Green M.D.

Address 3009 Evergreen Ave Date signed 5/27/45

Baltimore 14. Maryland.

G29221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29221 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 St Dunstan Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Rudolph Hembe.

3 (b) If veteran, name war World War #1
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ethel A. Hembe.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1895.

8. AGE: Years 49. | Months 10 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Executive
11. Industry or business Equitable Fuel Co.

FATHER
12. Name William F. Hembe
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary B. Lotus
15. Birthplace Md.

16 (a) Informant Ethel Hembe.
(b) Address 617 St Dunstans Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tichner & Son
(b) Address Balto., Md.

19 (a) MAY 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1945 at 7:56 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1945 to 5-25 1945.
and that I last saw h. alive on 5-25 1945.

Immediate cause of death C-R failure
Due to Arteriosclerotic Heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D.
Address U.M.H. Date signed 5-25-45 M. D.

G29222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G29222 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1742 E. Balt St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Slutzkin (SLUTZKIN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob Berman

13. Birthplace Russia

MOTHER 14. Maiden Name Fannie

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-45 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Old Pikesville Rd

18 (a) Funeral director Jack Levin Inc.

(b) Address 1439 E Balt St

19 (Date received by registrar) MAY 27 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1945 to 5-25 1945, and that I last saw h[illegible] alive on 5-25 1945

Immediate cause of death	Duration
Status Epilepticus	
Due to Congenital Epilepsy	
Due to	
Other Conditions Pneumonia - bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jerome R. Harlem M. D.

Address Sinai Hospital Date signed 5-26-45

85

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29223

1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30B

G29223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 yrs 5 mos 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Lancaster (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Cochran Cameron Slaymaker

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16th 1868

8. AGE: Years 76 | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace Pottstown, Pa. (Town, county, and state)
10. Usual Occupation Bookkeeper Retired
11. Industry or business Slaymaker Lock Co.,

FATHER
12. Name Samuel C. Slaymaker
13. Birthplace Salisbury Township Lane Co. Pa.

MOTHER
14. Maiden Name Jane Elizabeth Fedderker
15. Birthplace Elizabeth Township Lane Co., Pa.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road, Balto.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 27th 1945 (month) (day) (year)
(c) Cemetery or crematory Lancaster
Location Lancaster, Penna.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Aves.

19 (a) MAY 27 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 1:59 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1928, to May 26 1945, and that I last saw him alive on May 26 1945.

	Duration
Immediate cause of death: Coronary Occlusion	1 day
Due to: Dementia Paralytica	16 yrs
Due to:	
Other Conditions: Diabetes Mellitus	16 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Slaymaker M. D.
Address 331 N. Guilford Ave. Date signed

APPALAGIA - X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G29224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G29224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Alabama (b) County Talladega
(c) City or town Sylacauga (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Hickman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widower

6 (b) Name of husband or wife Celena Baker
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 9 1888

8. AGE: Years	Months	Days	If less than one day
57	1	17	hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Textile Work-

FATHER
12. Name Benjamin F. Hickman
13. Birthplace Alabama

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John Albert Hickman
(b) Address 2419 Joppa Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Brown Funeral Home
Location Birmingham, Alabama

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

MAY 27 1945 Date rec'd by registrar (a) (b) Huntington Williams, Baltimore, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1945, at 2.09 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1945, to 5/26 1945, and that I last saw him alive on 5/26 1945.

	Duration
Immediate cause of death Circulatory Failure	1 d.
Due to Profound Shock	1 d.
Due to Hemorrhage + Perforation from Perf. Peptic ulcer	hrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/26/45
Major findings of operation: Large perforation of Peptic Ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F Wiesperger M. D.
Address Mercy Hosp. Date signed 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

942 Registered No. G29225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Worth William Duffer

3 (b) If veteran, name war

3 (c) Social Security Account No. 382-09-2740

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Linnie

6 (c) If alive, give age 1895 years

7. Birth date of deceased (mo., day, yr.) Nov 17 1892

8. AGE: Years 52 49 | Months 6 5 | Days 4 | If less than one day hr. min.

9. Birthplace Fayetteville N.C. (Town, county, and state)

10. Usual Occupation Burner

11. Industry or business Navy Yard

FATHER
12. Name Charles Duffer
13. Birthplace unknown

MOTHER
14. Maiden Name Willie Owens
15. Birthplace North Carolina

16 (a) Informant Linnie Duffer
(b) Address 633 N. Calvert St

17 (a) Removal (b) Date thereof 5/28/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rockfish
Location Fayetteville N. C.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) MAY 28 1945 (b) (Date received by Registrar) Registrar

VS 151 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 19 45, at 3:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature F. A. Schmake M.D. Medical Examiner.
Date signed 5/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 853a

Registered No. G29226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 E. Hoffman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 E. Hoffman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Olney Funk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Nellie Funk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 9 - 1873

8. AGE: Years	Months	Days	If less than one day
72	4	15	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Canton Bot. Co

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Mrs Pickerman
(b) Address 2036 E. Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director Wilhoyte & Son Inc
(b) Address 1217 E. Fayette St

19 (a) MAY 28 1945 (b) Registrar
(Date received by local registrar) Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 2.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1945 to May 24 1945, and that I last saw h. alive on May 24 1945

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Schumacher
Address 1101 d. Milton Ave Date signed 5-26-45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

029227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 029227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Bretton Place (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH DOLBEY SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dr. B. Holly Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1884

8. AGE: Years 60 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John H. Delany
13. Birthplace Virginia

MOTHER
14. Maiden Name Emilie Higgenbother
15. Birthplace Maryland

16 (a) Informant Dr. B. Holly Smith (husband)
(b) Address 416 Bretton Place, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Henry W. Rukert's Sons Co.
(b) Address McCulloh & Richards Sts.

DATE RECEIVED MAY 29 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 11:19 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 25 1945, and that I last saw her alive on May 25 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Terminal myocardial decompensation	
Due to Arteriosclerotic cardiovascular disease	
Other Conditions Overwhelming infection (Multiple intra-abdominal abscesses)	

(Include pregnancy within 3 months of death)

Date of operation April 29, 1945
Major findings of operation: None
of autopsy: Multiple Abscesses

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature W. K. Dulaney M.D.
Address Union Memorial Hospital Date signed 5/28/45

X

G29228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

G29228 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Jane Walters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 45

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Harry A Walters
13. Birthplace Penna

MOTHER
14. Maiden Name Margaret Ahlen
15. Birthplace Penna

16 (a) Informant Mrs Margaret Walters
(b) Address 704 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Pulaski Highway

18 (a) Funeral director John F Denny Bro
(b) Address 715 Light St

19 (a) Date received by local registrar MAY 28 1945 (b) Signature of local registrar Wilson Blvd MD

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 7.41 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1945, to May 26 1945, and that I last saw h[illegible] alive on May 26 1945.

Immediate cause of death	Duration
Asphyxiation	
Due to	
Due to Extensive burns at birth	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 164 W Hamburg St Date signed 5/28/45

G29229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29229

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3522 Seventh St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)

(d) Street No. 3522 Seventh St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** William Schaum

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	20	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Jacob Schaum

13. Birthplace Germany

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Ada Chaneski

(b) Address 3522 Seventh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Annapolis Blvd.

18 (a) Funeral director John J. Kenny Inc.

(b) Address 715 Light St.

19 MAY 28 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** May 25th 1945, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN- 1942, to MAY 25 1945, and that I last saw him alive on MAY 22 1945

Immediate cause of death	Duration
Acute Coronary Occlusion	May 24-25
Due to Arterio-Sclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Luban M. D.

Address 328 Catalpa Ave Date signed 5/25/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G29230 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 786 Linwood St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) ~~County~~ Balto City
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 786 Linwood St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mathilda Agnes Curran

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Wid

6 (b) Name of husband or wife Frank Curran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 - 1855

8. AGE: Years 89 | Months 6 | Days 13 | If less than one day — hr. — min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business —

FATHER 12. Name John Barry

13. Birthplace Ireland

MOTHER 14. Maiden Name Nabby O'Connor

15. Birthplace Ireland

16 (a) Informant Mrs. Agnes Brennan

(b) Address 786 Linwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/1945 (month) (day) (year)

(c) Cemetery or crematory St Denis

Location Harford Rd.

18 (a) Funeral director Stanley F. Arnavord

(b) Address 4204 Ridgewood Ave

MAY 28 1945 Huntington Williams M.D.
(Date received by registrar)

VS 8 Approved Howard J. Madden M.D. Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 8:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944, to May 27 1945, and that I last saw her alive on May 25 1945.

Immediate cause of death: Hypostatic Pneumonia — Duration 4 days

Due to Age & Fracture Left hip — 3 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 21, 1945 at — M
(c) Where did injury occur? 786 Linwood St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home (Specify type of place) While at work? No
(e) Means of injury Fell from chair at home.

23. Signature Mrs. Johnson

Address 403 Med Arts Bldg Date signed 5/31/45

G29231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. G29231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale & Eutaw Place
(c) Hospital or institution (Home) Allamont Hotel
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eutaw Pl. & Lanvale
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Cassandra Ann Mackenzie

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-19-1854

8. AGE: Years 90 | Months 10 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Thomas Mackenzie

13. Birthplace Md.

MOTHER 14. Maiden Name Eleanora Brevitt

15. Birthplace Md.

16 (a) Informant Mrs. Catherine M. Brevitt (sister)

(b) Address Allamont Hotel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (month) (day) (year)

(c) Cemetery or crematory Friends Burying Gd

Location Harford Rd & 25th St.

18 (a) Funeral director Edwin Mannis.

(b) Address 1018 W North Ave.

19 (a) MAY 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26/45 19..., at ...M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1936 to 5/26 1945, and that I last saw her alive on 5/26 1945.

Immediate cause of death Myocarditis Arterio-Sclerosis

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration: Gradual

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ...M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature W H Moody

Address 1403 Park Ave Date signed 5/29/45

G29232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 3 / a

Registered No. G29232

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305-E-29½ St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305-E-29 St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Telle Richardson

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah M. Richardson

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Sept-15-1865

8. AGE: Years 79 | Months 8 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Queen Anne Co. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Benj F. P. Richardson
13. Birthplace Queen Anne Co. Md

MOTHER
14. Maiden Name Louisa Legg
15. Birthplace Queen Anne Co. Md.

16 (a) Informant Miss Avis V. Richardson (daughter)
(b) Address 305-E-29½ City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount-Md.

18 (a) Funeral director Stewart Memorial
(b) Address 128 W Mont Ave.

19 (a) MAY 28 1945 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944, to May 25 1945, and that I last saw h... alive on May 25 1945.

	Duration
Immediate cause of death: Chr. Myocarditis	5 yrs
Due to: Arteriosclerotic cardio vascular renal disease	5 yrs
Due to:	
Other Conditions: Bronchial asthma	2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Alessi M. D.
Address 6217 Harford Rd Date signed 5/29/45

VS 150

MARGIN RESERVED FOR BINDING

"PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 168 Ellwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 165 Ellwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Augusta Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward Kane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1890

8. AGE: Years 53 | Months - | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER 12. Name Julius Lissling
13. Birthplace Germany

MOTHER 14. Maiden Name Mary McNamac Kess
15. Birthplace Germany

16 (a) Informant Mrs Dora Mahaney
(b) Address 2415 Llewellyn ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 47 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Cemetery
Location

18 (a) Funeral director Welsh Funeral Home
(b) Address 200 E Orleans St

19 MAY 28 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 1.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24, 19 45 to May 25 1945, and that I last saw h alive on May 25, 19 45.

Immediate cause of death Coronary thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions Phlebitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney L. Levy M. D.

Address 25 W Eutaw Place Date signed 4/29/45

VS 180 Have spoken to Dr. Davis, Medical examiner, & told to sign this X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

352598 G29234 — BALTIMORE CITY HEALTH DEPARTMENT — G29234

CERTIFICATE OF DEATH 122a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 A Regester (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Richwalski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Phillip Richwalski
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 1-28-03

8. AGE: Years 42 | Months 3 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fred Lemke
13. Birthplace Germany

MOTHER
14. Maiden Name Catheran Swindeski
15. Birthplace Poland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 '45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 (a) ..... (b) ..... (Date received by Registrar) Registrar

MAY 28 1945 Huntington Williams, M.D.

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27- 1945 at 12 07 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to 5-27- 1945. and that I last saw her alive on 5-27- 1945.

Immediate cause of death Strangulated umbilical hernia — Post op.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-26-45

Major findings of operation: Strangulated loops of bowel

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Williams, M.D.
Address The Johns Hopkins Hosp Date signed 5-27-45

Spec.—6-9-19—H. P. Co.—1000 Blks.

G29235

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29235

CERTIFICATE OF DEATH.

46 B

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 S. Glover St ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Milanicz

(a) RESIDENCE. No. 615 S. Glover St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Pfc. Frank J. Milanicz

6 DATE OF BIRTH (month, day, and year) OCT. 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W Operator

(b) General nature of industry, business, or establishment in which employed (or employer) S.S.# S.220 03 3018

(c) Name of employer Glen L Martin

9 BIRTHPLACE (city or town) (State or country) BALTO. MD.

PARENTS

10 NAME OF FATHER John Cruci

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Helen Mrozinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant FRANK J. MILANICZ (HUS.)
(Address) 615 S. GLOVER ST.

15 Filed ....., 19 ..... Huntington Williams M.D.

MAY 28 1945

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 25 1945

17 I HEREBY CERTIFY, That I attended deceased from Dec 5/44, 19..., to May 25/45, 19..., that I last saw h.. alive on May 18/45, 19..., and that death occurred, on the date stated above, at 12/30 P.m.

The CAUSE OF DEATH* was as follows:

Lumen Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Dropsy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/8/44

Was there an autopsy? No.

What tests confirmed diagnosis? Path. specimen

(Signed) John J. Kroger, M. D.

, 19 (Address) 2037 Eastlake Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	MAY29/45

20 UNDERTAKER Lilly and Zeiler INC. ADDRESS 403 S. WOLFE ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WALTJEN ✓

G29236 BALTIMORE CITY HEALTH DEPARTMENT G29236

CERTIFICATE OF DEATH 1278 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 E Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M [illegible] Seifert

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Adam Seifert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-19-1867

8. AGE: Years 77 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Conrad Betz
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Maria Betz
15. Birthplace Germany

16 (a) Informant Mrs Frieda Wedig
(b) Address 2112 E Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Frederick Road

18 (a) Funeral director Albert L Hill Jr
(b) Address 1606 N Chester Street

19 (a) (Date received) AUG 8 1945 (b) Huntington Williams, M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945 to 5/24 1945 and that I last saw h alive on 5/24 1945.

Immediate cause of death Septicemia — Duration

Due to Pentonitis

Due to Ruptured gall bladder

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur Crockett M. D.
Address Sinai Hosp. Date signed 5/29/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

Registered No. G29237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave + Underland Ave.
(c) Hospital or institution:
West Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town GREEN HAVEN
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5th + OUTING AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Hannan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife JAMES J. HANNAN
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) MAY. 26- 1908

8. AGE: Years	Months	Days	If less than one day
37	0	0	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business —

FATHER
12. Name JOHN L HOFFMAN
13. Birthplace BALTO MD

MOTHER
14. Maiden Name EMMA KELLY.
15. Birthplace IRELAND

16 (a) Informant JAMES J. HANNAN
(b) Address GREEN HAVEN MD

17 (a) BURIAL (b) Date thereof 5-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A-A-Co

18 (a) Funeral director Bernard C Hasler
(b) Address 121 E WEST ST. Westminster Williams, Md

MAY 28 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26/45 19 , at 4 A.M

21. I certify that death occurred on the date above stated: that I attended deceased from 5/16/45 19 , to 5/26/45 19 , and that I last saw h alive on 5/24/45 19 .

Immediate cause of death Respiratory Failure
Due to Toxic liver
Due to Acute yellow Atrophy of liver (Probably)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Doukas M. D.
Address U. B. G. H. Hospital Date signed 5/26/45

VS 150

G29238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29238 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 Allendale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Allendale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter D. Colquitt

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary G. Colquitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1870

8. AGE: Years 74 | Months 5 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Machinist B. & O. R.R.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Walter L. Colquitt
(b) Address 516 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAY 28 1945 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27 1945 at 10:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. J. Salminka M.D. Medical Examiner.
Date signed 5/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G29239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert S. Smedley

3 (b) If veteran, name war --
3 (c) Social Security Account No. 00-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1944

8. AGE: Years	Months	Days	If less than one day
	7	3 4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation ----
11. Industry or business

FATHER
12. Name Bedford L. Smedley
13. Birthplace pront Royal Va.

MOTHER
14. Maiden Name Marie A. Mursion
15. Birthplace Scotland

16 (a) Informant Bedford L. Smedley
(b) Address 1505 Poplar-Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAY 28 1945 (Date rec'd by registrar) Huntington Will Data, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27 1945, at 1:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Kubinski M.D. Medical Examiner.
Date signed 5/27/40

VS 151

G29240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G29240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Josephh's Hospital 24
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 50
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Henry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mrs. Catherine A. Freburger

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Robert E. L. Freburger
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6/26/93

8. AGE: Years	Months	Days	If less than one day
51	10	29	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business Housewife

FATHER
12. Name Thomas Clark
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Duffy
15. Birthplace Ireland

16 (a) Informant Robert E. L. Freburger
(b) Address 1436 Henry St.

17 (a) Burial (b) Date thereof May 29. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flanagan & Flanagan
(b) Address 1426 Light St.

19 (a) MAY 28 1945 (b) Huntington Mitchell, Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH 5/25/45 19..., at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5/45 19..., to 5/25/ 19 45, and that I last saw her alive on 5/25/ 19 45.

Immediate cause of death Terminal Respiratory Failure — Duration .....
Due to Post-operative complication — Duration .....
Due to Intestinal Obstruction due to adhesions — Duration .....
Other Conditions..... — Duration .....
(Include pregnancy within 3 months of death) — Duration .....
Date of operation 4/21/45
Major findings of operation: adhesions regional ileitis
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....
23. Signature Edward Scavone M.D.
Address St. Joseph's Hosp Date signed 5/25/45

X

G29241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29241 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mins
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 E. Fort ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Walsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fannie Walsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	3	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Bethlehem Fairfield

FATHER
12. Name ?
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Devaney
15. Birthplace Ireland

16 (a) Informant Mrs. Fannie Walsh
(b) Address 511 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Hill
Location A. G. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 414 Light St.

19 MAY 28 1945 (Date signed) (By whom filed) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1945, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1945 to 5-25 1945, and that I last saw h[illegible] alive on 5-25 1945.

Immediate cause of death Coronary thrombosis — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Arbaugh M.D.
Address 513 Light St Date signed 5-25-45

VS 180

Affidavit by Thomas J. Maddox, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29242
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 665 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Wright

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 - 1943

8. AGE: Years 1 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Milton Wright
13. Birthplace Va

MOTHER
14. Maiden Name Annie Mosley
15. Birthplace Kentucky

16 (a) Informant Milton Wright
(b) Address 665 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1945 (month) (day) (year)
(c) Cemetery or crematory Wheel Wright Kentucky
Location

18 (a) Funeral director Roff C. & B. M. Walker
(b) Address Frith & Hooker Co Huntington W. Virginia

19 MAY 28 1945 (State or local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27 1945, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1945, to 5-27 1945, and that I last saw her alive on 5-27 1945.

Immediate cause of death: Whooping Cough — Duration: 3 days
Due to: toxemia + Dehydration
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. K. Kozerian M.D.
Address Franklin Square Hosp Date signed 5-27-45

For C. R. P. Davis, by Howard J. Mendelis, M.D.

G29243 Rohls

BALTIMORE CITY HEALTH DEPARTMENT 39C

CERTIFICATE OF DEATH

Registered No. G29243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Waverly
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Rahls ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-42

8. AGE: Years: 2 yrs | Months: 11 | Days: - | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Amer Rahls
13. Birthplace Maryland

MOTHER
14. Maiden Name Ryde Jones
15. Birthplace Maryland

16 (a) Informant Mrs Rhodes
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 45 (month) (day) (year)
(c) Cemetery or crematory Christ Church
Location Waverly, Md.

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1940 Eutaw Place Baltimore, Md.

19 (a) MAY 28 1945 (Date received by Registrar) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945, to May 27 1945, and that I last saw him alive on May 27 1945.

Immediate cause of death: Tick bite fever — Duration: 18 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Hatfield M. D.
Address Johns Hopkins Hospital Date signed 5-27-45

VS 150

Dr. Gordy.

G29244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. G29244

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5407 Elsrode Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5407 Elsrode Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick G. Mack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Barbara a.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30-1872

8. AGE: Years 72 | Months 5 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto- Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Thomas Mack
13. Birthplace Germany

MOTHER
14. Maiden Name (Catherine ?)
15. Birthplace

16 (a) Informant Mrs. Edward Adolph
(b) Address 5407 Elsrode Avenue

17 (a) Burial (b) Date thereof 5-29-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Luckett
(b) Address 5305 Harford Rd

MAY 28 1945 (b) Hunting the Williams, M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to May 25 1945 and that I last saw him alive on May 23 1945.

Immediate cause of death: Carcinoma of Left Lung — Duration 1 1/2 yrs

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence none at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 5706 Harford Rd Date signed 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G29245 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: SBGH. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Patapsco St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John C. Fitzpatrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-xx-1881

8. AGE: Years 63 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation electrical insp.

11. Industry or business

FATHER 12. Name James A. Fitzpatrick
13. Birthplace Balto.

MOTHER 14. Maiden Name Josephine Lovett
15. Birthplace Va

16 (a) Informant Clara Krouse
(b) Address 1409 S Charles St.

17 (a) Burial (b) Date thereof 5-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md.

18 (a) Funeral director Leonard J Finch
(b) Address 5305 Harford Rd.

19 MAY 29 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-xx- 1945, at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9- 1945 to 5-25- 1945 and that I last saw h. alive on 5-25- 1945.

Immediate cause of death: Pulmonary embolism — Duration

Due to: Portal Chirrhosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H Ehrlich
Address 1213 Light St. Date signed 5-29-45

G29246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G29246 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 E. 35th St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. 35th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Irvin Marshall Plummer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 221-07-3931

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Sarah Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27th 1883

8. AGE: Years 62 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Queen Anne Co. Md. (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Wm. H. White & Co

FATHER
12. Name Bascom Plummer
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Slaughter
15. Birthplace Md.

16 (a) Informant Mrs. Sarah C. Plummer
(b) Address 508 E. 35th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/29/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sudlersville
Location Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAY 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25th 1945, at 5.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945 to May 25 1945, and that I last saw him alive on May 25, 1945.

Immediate cause of death: Lobar Pneumonia — Duration 2 days

Due to Acute Bronchitis — 16 days

Due to Acute Pulmonary Edema — 16 days

Other Conditions Acute Frontal Sinusitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Bortz, M.D.
Address 331 S. North Ave Date signed 5-27-45

VS 150

G29247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G29247 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) since 3/3/25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3619 Purdue Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles C. Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1829

8. AGE: Years 15 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Reisterstown, Balto. Co., Md. (Town, county and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Charles F. Allen
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary T. Soter
15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs. Charles F. Allen
(b) Address 3619 Purdue Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30/25 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Road

18 (a) Funeral director Elmer W. Conkling & Son
(b) Address 924 E. Eager St.

19 (a) 5-30-1925 (Date received by registrar) (b) Huntington Wilson Registrar M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1925, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
1st - 2nd - 3rd Degree Burns of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/3/25 at 2:00 P.M. 27-13
(b) Where did injury occur? Lake and Roland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Academy Visitation While at work? No
(d) Means of injury Burning Brush & Kerosene

23. Signature G. L. Turbinetti M.D. Medical Examiner.
Date signed 5/27/25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G29248 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2803 GARRISON AVE.

(c) Hospital or institution:

NURSING HOME. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4.MONTH

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)

(d) Street No. 758 LINNARD STREET. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME ROSA LEDOYEN.

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife XX CHARLES E. LEDOYEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.13, 1867

8. AGE: Years	Months	Days	If less than one day
77	7	13	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name Clarence J. McKenna

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary Ann O'Sullivan

15. Birthplace ?

16 (a) Informant Mrs. John W. Rommal

(b) Address 758 Linnard St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) (b) Huntington Williams, Registrar

MAY 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 26 1945. 19 , at 5P.M M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN.26 1945 to MAY 26. 1945, and that I last saw her alive on MAY 26 1945.

Immediate cause of death

	Duration
CHRONIC MYOCARDIAL DEGENERATION	
Due to ARTERIOR SCLEROSIS	1944.
Due to	1944.
Other Conditions FRACTURE LEFT FEMUR JANUARY 26.1945(AT HOME)	

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Acc. 16/8

(b) Date of occurrence 1/26/45 at ? M

(c) Where did injury occur? 758 Linnard St. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify home or place) While at work? no

(e) Means of injury Slipped and fell at home

23. Signature Chas. F. Adelsberg M.D.

3013 ST PAUL STREET MAY 26 1945

Address Date signed

For Dr. J. Sutkowski, by Howard J. Mueller, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Amerlie Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Martin Frederick Rheinhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Dorothea R Reinhardt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-1888.

8. AGE: Years 57. Months 4 Days 0. If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Claim Clerk

11. Industry or business

FATHER
12. Name Conrad Rheinhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Conrad.
15. Birthplace Md.

16 (a) Informant Dorothea R Reinhardt
(b) Address 702 Amerlie Rd. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Chas E Franck
(b) Address 570 Rockspring Rd

19 (a) (Date rec'd by registr.) (b) 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1945 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1945 to 5-26 1945 and that I last saw h alive on 5-26 1945

Immediate cause of death C-R failure — Duration

Due to Cerebral Hemorrhage

Due to Hypertensive C-V disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John U. Morris M. D.
Address UMH. Date signed 5-26-45

VS 150

WG29250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

G29250 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore C.B
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. Balto St
(If rural-give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ambrose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11th 1887

8. AGE: Years	Months	Days	If less than one day
58	3	15	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Ambrose
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Biemert
15. Birthplace Germany

16 (a) Informant Sister-Frances Gardner
(b) Address 4331 Berger Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank J. Pepitone
(b) Address 2818 E. Baltimore

MAY 28 1945 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1945, at 4:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subinsky M.D.
Medical Examiner.
Date signed 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29251
474292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G29251
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 S Montford Ave
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 S. Montford (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Yanukowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-0515

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife John James.
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 11-1-1903

8. AGE: Years	Months	Days	If less than one day
41	6	23	hr. min.

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER
12. Name Joseph Sowa
13. Birthplace Poland.

MOTHER
14. Maiden Name Zelaba.
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29-45 (month) (day) (year)
(c) Cemetery or crematory Saint Stanislaus
Location Baltimore, Md.

18 (a) Funeral director John J. Duda
(b) Address 2829 - Hudson St.

19 (a) (Dispos'd by registrar) (b) Registrar
MAY 28 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 24 1945, at 9. P M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 23 1945, to May - 24 1945, and that I last saw h. alive on May - 24 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert A. Walters M.D.
Address Johns Hopkins Hosp. Date signed 5/27/45

G29252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29252 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 Hillen St
(c) Hospital or institution: 5-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 Hillen St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lewis James Brown Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Florist Sto

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Lena Brown
(b) Address 1034 Hillen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Joseph C. Locke Jr
(b) Address 1304 N. Central Ave

19 (a) MAY 29 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/45 to 5/24/45
and that I last saw h alive on 5/24/45.

Immediate cause of death: Bronchopneumonia — Duration 2 wks
Due to: Acute Rheumatic Fever — 6 wks
Due to: Arteritis — 6 mos
Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Blake M. D.
Address 1307 N. Central Ave Date signed 5/28/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057762 G29253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G29253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Oakland Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Patsy Rogers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-19-94

8. AGE: Years	Months	Days	If less than one day
50	2	7	.....hr. .....min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. Dixon
13. Birthplace Va

MOTHER
14. Maiden Name Jane Dean
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. County, Md.

18 (a) Funeral director Joseph W. Locke
(b) Address 1304 Eastern Ave

19 (a) MAY 29 1945 (b) .....
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1945 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945 to May 26 1945 and that I last saw h[illegible] alive on May 26 1945

Immediate cause of death	Duration
Uremia	2 mos
Hypertension	10 yrs
Arterio-sclerosis	
Due to disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

Signature Edward S. Newman M. D.
Address J.H. Hospital Date signed 5-26-45

VS 190

G29254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57B

G29254 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Balto Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County WASHINGTON
(c) City or town CAVETOWN
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BASIL WOLFE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
10			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name WADE R WOLFE
13. Birthplace Md.

MOTHER
14. Maiden Name IRENE Smith
15. Birthplace Md.

16 (a) Informant WADE R. WOLFE
(b) Address SAME

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/45 (month) (day) (year)
(c) Cemetery or crematory Smithsburg Cem.
Location Smithsburg Md

18 (a) Funeral director A N Hoffman
(b) Address Hagerstown Md.

19 (a) (Date rec'd by registrar) MAY 28 1945 Registrar

Huntington for Milwaukee, Wis.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27 1945, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1945 to 5-27 1945, and that I last saw h[illegible] M alive on 5-22 1945.

Immediate cause of death	Duration
RESPIRATORY AND CARDIAC FAILORE	
Due to MEDULLARY COMPRESSION	
Due to CEREBELLAR TUMOR	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5-23
Major findings of operation: CEREBELLAR TUMOR
of autopsy: CEREBELLAR TUMOR

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R R Norment M. D.
Address Univ. Hosp. Date signed 5/29/45

VS 150

X

G29255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29255

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Av & Madison St.
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Leonardtown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Widowed

6 (b) Name of husband or wife Widower
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	8	hr. min.

9. Birthplace St. Mary's Co., Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alexander Stevens
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary Holley
(b) Address 1926 Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-45 (month) (day) (year)
(c) Cemetery or crematory St. John Cem.
Location St. Marys Co., Md.

18 (a) Funeral director Pius B. Robinson
(b) Address Dameron, St. Mary Co., Md.

MAY 28 1945 Harrington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27 1945, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1945 to 5-27 1945 and that I last saw him alive on 5-27 1945

Immediate cause of death Arteriosclerotic - Cardio vascular disease — Duration

Due to

Due to

Other Conditions Senile balmnitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luke Godbon M. D.
Address Md. Gen. Hospital Date signed 5-29-45

G29256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29256 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3509 Elm Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3509 Elm Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John R. Barnes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Laura Barnes.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 19 1860

8. AGE: Years	Months	Days	If less than one day
85	3	8	hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Retired Blacksmith

11. Industry or business Bethlehem Steel Co.

FATHER

12. Name Joseph A. Barnes.

13. Birthplace Maryland.

MOTHER

14. Maiden Name Sarah Brown

15. Birthplace Maryland.

16 (a) Informant Miss. Hattie N. Barnes

(b) Address 3509 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Poplar, Location Balto Co, Md.

18 (a) Funeral director Ehrenfeld & Sonovan

(b) Address 3615-17 Chestnut Ave.

19 (a) MAY 28 1945 (b) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944, to May 27 1945, and that I last saw him alive on May 26 1945.

	Duration
Immediate cause of death Bronchopneumonia	5 days
Due to Arteriosclerotic Heart Disease	15 years
Due to Heart failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Wallenstein M. D.

Address 848 N 36th St Date signed 5/27/45

X

G29257

473504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G29257

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6717 German Hill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Hopka.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-5020

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mathilda Hopka
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 2-2-86.

8. AGE: Years 59 | Months 3 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ? ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant Brenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof 5-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd. Balto Co. Md.

18 (a) Funeral director Schaefer & Zeiler
(b) Address 3605 Fait Ave.

19 (a) MAY 26 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MAY 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May-25 1945, at 2.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May-8 1945, to May-25 1945, and that I last saw him alive on May-25-1945.

Immediate cause of death: Respiratory failure — Duration:

Due to: Pneumonia LLL, untyped pneumococcus — Duration: 1 week

Due to: Bronchiectasis & emphysema — Duration: 9 yrs

Other Conditions: Hydropneumothorax, left

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Benecar, M. D.
Address J. Hopkins Hosp Date signed 5-25-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

G29258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15/16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Willard E. Van Deusen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha W. Van Deusen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1864

8. AGE: Years	Months	Days	If less than one day
80	6	21	hr. min.

9. Birthplace Virginia (Herndon) (Town, county, and state)
10. Usual Occupation Retired - Prop.
11. Industry or business Walbrook Laundry

FATHER
12. Name William A. Van Deusen
13. Birthplace New York

MOTHER
14. Maiden Name Mary Witchens
15. Birthplace New York.

16 (a) Informant Mrs. Martha W. Van Deusen
(b) Address 3210 Walbrook Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Wash., N. C.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Burial Permit No. Mil

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945, to 5/28 1945, and that I last saw him alive on 5/27 1945.

Immediate cause of death	Duration
Debility	
hypostatic pneumonia	
Due to Fract of L. femur	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 15/6
(b) Date of occurrence 5/7/45 at M
(c) Where did injury occur? Balto., Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At Home (Specify type of place) While at work? No
(e) Means of injury Fall - Bathroom floor.

23. Signature Paul F. Herold M. D.
Address Md. Gen. Hosp. Date signed 5/28/45

VS 150 MAY 28 1945 J. Dubowski, Dr Thomas L. Marcey, M.O.X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DONAHUE

G29259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111a

G29259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Ellicott Driveway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** PATRICK B. DONAHUE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret M. Donahue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/1904

8. AGE: Years	Months	Days	If less than one day
40	8	5	hr. min.

9. Birthplace Carlos, Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Sparrows Pt. R. R.

FATHER
12. Name Peter S. Donahue
13. Birthplace Phoenix, Md.

MOTHER
14. Maiden Name Margaret Watson
15. Birthplace Franklin, Md.

16 (a) Informant Mrs. Margaret M. Donahue
(b) Address 1141 Ellicott Driveway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) MAY 28 1945 Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1945 to 5/27 1945 and that I last saw h[illegible] alive on 5/27 1945

Immediate cause of death	Peripheral vascular Collapse.	Duration
Due to	Massive Pulmonary Embolism	
Due to	?	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reclaninger M. D.
Address Univ. Hosp. Date signed 5/27/45

Blaninger X

G29260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G29260 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4807 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOSEPH WHITTEN

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-09-9155

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Annette C. Harr
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Apr. 28. 1880
8. AGE: Years 65 | Months | Days 27 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Asso. Tile & Marble Co.

FATHER
12. Name Thomas Whitten
13. Birthplace Baltimore

MOTHER
14. Maiden Name Barbara Wieman
15. Birthplace Baltimore

16 (a) Informant Mr. T. Ross Whitten (Son)
(b) Address 5806 Key Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May. 29. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway.

19 (a) Date received MAY 29 1945 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May. 25. 1945 at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1945 to 6/25 1945. and that I last saw him alive on 5/25 1945.

Immediate cause of death Myocardial insufficiency — Duration 3 wks.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Grayton M. D.
Address 3963 Greenmount Date signed 5/26/45.

X

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

629261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 629261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sheila Frey

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jesse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/26/1875

8. AGE: Years 70 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Winfield, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rosa Causely
13. Birthplace Md

MOTHER
14. Maiden Name Laura
15. Birthplace Md.

16 (a) Informant Sarah Frey (Daughter)
(b) Address 607 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Mt. Airy Md.

18 (a) Funeral director Charles H. Hoffman
Address 607 N. Carrollton Ave.

MAY 28 1945 (Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/45 19 ; at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1945, to May 28 1945, and that I last saw her alive on May 25 1945.

Immediate cause of death Unknown
Probably Diabetes mellitus & cerebral thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Milton E. Drake M. D.
Address Univ. Hosp. Date signed 5-28-45

VS 150

X

G29262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G29262

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anderson Delaney

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/1870

8. AGE: Years 69 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Charlotte, Va. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Anderson Henry
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Winston
15. Birthplace Va.

16 (a) Informant Easton Poole (Daughter)
(b) Address 503 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Baltimore, County, Md.

18 (a) Funeral director Charles O. Cooper
(b) Address 512 N. Carrollton Ave

MAY 28 1945 (Date rec'd by registrar) (b) Hamilton for Willis Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th 1945, at 6:30 M

21. I certify that death occurred on the ~~date~~ above stated; that I attended deceased from 5/23/45 to 5/24/45 and that I last saw h[illegible] alive on 5/24/45

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Left sided Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Welcome M. D.
Address 1131 Hadow Rd Date signed 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G29263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 Hazelwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Hazelwood
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Hazelwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Plumer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Teresa Raab
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1864

8. AGE: Years	Months	Days	If less than one day
81		23	hr. min.

9. Birthplace Raspeburg, Baltimore County
(Town, county, and state)
10. Usual Occupation Truck farmer
11. Industry or business

FATHER
12. Name Edw. Plumer
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Clara Rathert
15. Birthplace Osnabruck, Germany

16 (a) Informant Miss. Anna Plumer
(b) Address 4614 Hazelwood Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer May 30 1945
Location Belair Rd.

18 (a) Funeral director Loiselle Funeral Home
Address 5713 Belair Rd.

19 (a) (Date rec'd by registrar) MAY 28 1945 Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1945, to May 26 1945, and that I last saw h im alive on May 26 1945.

Immediate cause of death: Myocardial-vascular-renal disease — Duration: 10 yrs. probably longer

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 5-28-45

VS 150

X

G29264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29264 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 White ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Frazier

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Wm W. Frazier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1866

8. AGE: Years 80 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Alexander Hart
13. Birthplace Md.

MOTHER
14. Maiden Name — Andrews
15. Birthplace Md.

16 (a) Informant Mrs. Dan. Dolan
(b) Address 3023 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto. Co. Md

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

19 MAY 29 1945 (Date rec'd) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27th 1945 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to May 27 1945 and that I last saw h.. alive on May 25 1945

Immediate cause of death: Cerebral Hemorrhage (apoplexy) — Duration: May 23 1945

Due to

Due to

Other Conditions Arterio Sclerosis — a number 7 years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Norris B. Green M. D.

Address 3009 Evergreen ave Date signed 5/28/45
Baltimore 14 Maryland

VS 3

G29265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G29265

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVELYN DOWNES CONNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Lester B. Conner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1910

8. AGE: Years	Months	Days	If less than one day
35	4	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Clement & Ball Shoe Co.

FATHER
12. Name Thomas Cecil Downes
13. Birthplace Millington, Md.

MOTHER
14. Maiden Name Minnie Edna Forrest
15. Birthplace Balto., Md.

16 (a) Informant Mr. Lester B. Conner
(b) Address 2405 Harlem Ave.

17 (a) Burial (b) Date thereof 5/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

MAY 28 1945
19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1945, at 5:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to May 26 1945; and that I last saw her alive on May 26 1945.

Immediate cause of death Hodgkins Disease — Duration One year

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Not

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Ave. Date signed May 28 '45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G29266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mosher St. + Fremont Ave
(c) Hospital or institution:
Maryland Neural Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 W. Burke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Weil

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Christian Weil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13, 1879

8. AGE: Years 66 | Months 1 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leo. D. Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Ebert
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Maryland

18 (a) Funeral director John Burns Sons
(b) Address Towson, Maryland

19 (a) MAY 28 1945 (b) Registrar
VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1945; at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945 to 5/26 1945 and that I last saw her alive on 5/25 1945

	Duration
Immediate cause of death Coronary occlusions (Thrombosis)	
Myocardial Infarctions	
Due to Hypertension, Cerebro-Vascular Disease	
Due to	
Other Conditions Chronic Glomerulitis.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy (Same as above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. S. Pugh M. D.
Address Md. Hosp. Hospital Date signed 5/26/45

Huntington Williams, M.D.

X

Dr Schmick

G29267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G29267
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mehling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis Mehling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1876

8. AGE: Years 68 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name James Mc Kenna
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Higgins
15. Birthplace Ireland

16 (a) Informant Mrs. Dorothy Schubert
(b) Address 5405 Reed Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto - Md.

18 (a) Funeral director Leonard J. Ryck
(b) Address 5505 Harford Rd.

19 (a) Date received MAY 29 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945 to May 26 1945, and that I last saw h[illegible] alive on May 25 1945.

Immediate cause of death: Coronary Thrombosis

	Duration
Due to	
Due to	
Other Conditions Cystitis, Sclerosis of Prostate, Hypertension	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Schmick
Address 1337 S. Charles St. Date signed 5/28/45

X

G29268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

PIRAINO

1927

G29268 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna W. Pirraino PIRAINO Pirraino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles Pirraino PIRAINO

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) June 1 1895

8. AGE: Years 49 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John O'Neill

13. Birthplace Somerset Co. Md.

MOTHER 14. Maiden Name Jennie Wallace

15. Birthplace Somerset Co. Md.

16 (a) Informant Charles Pirraino PIRAINO

(b) Address 2624 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location Mall Ave.

18 (a) Funeral director John C. Melly Sons

(b) Address 24 E. O'Donnell St

19 (a) MAY 28 1945 Huntington Williams M.D. (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from (2) 19 , to 5-25 1945.
and that I last saw h alive on 5-25 45

Immediate cause of death Coronary Occlusion

Due to Hypertension Cardiac

Other conditions

(Include pregnancy, within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Mysch M. D.

Address 1301 Mathews St Date signed 5-26 1945

(over)

G29269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G29269

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 13 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Margaret Culotta Fetting

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Anton W. Fetting
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------- 3/6/83

8. AGE: Years	Months	Days	If less than one day
62	2	22	— hr. — min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Roney
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary -------
15. Birthplace Ireland

16 (a) Informant John H. Fetting
(b) Address 4306 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) MAY 28 1945 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945, at 10:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1945 to 5/24 1945 and that I last saw her alive on 5/24 1945

Immediate cause of death	Duration
Carcinoma of face.	2
Due to (Epidermoid)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/13/44 Biopsy
Major findings of operation: Epidermoid C.A. Face.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Sigmund Roney M. D.
Address Bon Secours Hosp. Date signed 5/26/45

VS 150

G29270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B

G29270 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Drive and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo.6da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2mo.9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State S.Carolina (b) County
(c) City or town Clifton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Lowery, Ralph Frank

3 (b) If veteran, name war

3 (c) Social Security Account No. 465-12-9475

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1901

8. AGE: Years	Months	Days	If less than one day
44	3	2	hr. min.

9. Birthplace Bath, South Carolina
(Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Seafaring

FATHER
12. Name Charles Lowery
13. Birthplace South Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore 18, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location 5800 Belair Ave

18 (a) Funeral director G. Lee Oder
(b) Address 4644 York Rd.

MAY 28 1945

(b) Registrar by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH May 22 1945, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar.14 1945, to May 22 1945, and that I last saw h im alive on May 22 1945.

Immediate cause of death Diffused purulent peritonitis — Duration 24 hrs

Due to Penetrating duodenal ulcer and partial gastric resection — Duration Unknown

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation May 18

Major findings of operation: Partial lap. gastric resection; explor

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature U.S. Marine Hospital M. D.
Address Baltimore 18, Md. Date signed 5/23/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G29271 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2417 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Assunta D'Adamio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Quirino D'Adamio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1889

8. AGE: Years	Months	Days	If less than one day
55 yrs.	8	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Domenico Cieri
13. Birthplace Italy

MOTHER
14. Maiden Name Antcinette Zocco
15. Birthplace Italy

16 (a) Informant Husband
(b) Address 2417 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

(a) Filed by registrar Huntington Williams (b) Registrar

MAY 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29/45 to 5/24/45 and that I last saw h~~er~~ alive on 5/24/45.

Immediate cause of death Carcinoma of Breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas E. Marck M.D.
Address 501 Nottingham Date signed 5/26/45

X

VS 150

G29272

JL - 93536 G29272 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orville Kemper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1917

8. AGE: Years	Months	Days	If less than one day
28	0	24	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kemper
13. Birthplace Ohio

MOTHER
14. Maiden Name Stella Bertkey
15. Birthplace Ohio

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5 31 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Delphos Ohio
Location Delphos Ohio

18 (a) Funeral director John M. Weber
(b) Address 110 S. Chester Street

19 (a) JUN 28 1945 (b)
(Date rec'd by registrar) Huntington, Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1945, at 11:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1945, to May 27 1945, and that I last saw h.im alive on May 27 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration (2)

Due to Pulmonary Tuberculosis (1)

Due to

Other Conditions T.B. of kidneys and prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address City Hospital Baltimore, Md. Date signed

X

G29273

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 74a

Registered No. G29273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Hopkins (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carroll Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife Alma Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1898

8. AGE: Years 47 | Months 3 | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Seafood Dealer

11. Industry or business

FATHER 12. Name Benedict H. Brown

13. Birthplace Reedsville Wa.

MOTHER 14. Maiden Name Rachael Bradshaw

15. Birthplace Pylerton Wa.

16 (a) Informant Alma Brown

(b) Address Hopkins Wa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)

(c) Cemetery or crematory Lutheran Cem.

Location Parkside Wa.

18 (a) Funeral director Wm. J. Weber & Son

(b) Address Martin & Lemmon Ave. Huntington Williams, Md.

19 (a) MAY 29 1945 (Date rec'd by Reg.) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945; at 2 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1945; to 5/28 1945; and that I last saw h. alive on 5/28 1945

Immediate cause of death: Lymphatic Leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Martin E. Strobel M. D.

Address Md. Genl. Hospital Date signed 5/29/45

X

G29274

473806.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G29274

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Delaware (b) County.....
(c) City or town Middletown.
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph le Gibbs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-11-92

8. AGE: Years 53 | Months 4 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Farming

11. Industry or business

FATHER
12. Name Isaac Gibbs
13. Birthplace Del.

MOTHER
14. Maiden Name Isabella Simmerson
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-45 (month) (day) (year)
(c) Cemetery or crematory St Anne's Cemetery
Location Middletown Del.

18 (a) Funeral director Edward F Gilligan
(b) Address Middletown Del.

19 MAY 29 1945 (b) Huntington Valley, Md.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 28 1945 at 1102 M

21. I certify that death occurred on the date above stated; that I attended deceased from May-14 1945 to May-28 1945 and that I last saw him alive on May-28 1945.

Immediate cause of death Peritonitis

Due to.....

Due to.....

Other Conditions Carcinoma

(Include pregnancy within 3 months of death)

Date of operation May 16, 1945

Major findings of operation: Carcinoma of stomach

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature W. Brumbaugh, M.D.
Address The Johns Hopkins Hospital Date signed May 29, 1945

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G29275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August F. Weis

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-3176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Isabelle

6 (c) If alive, give age 60+ years

7. Birth date of deceased (mo., day, yr.) July 20, 1880

8. AGE: Years	Months	Days	If less than one day
64	10	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Balto. Sewerage Lighter Co.

FATHER
12. Name August Weis
13. Birthplace ~~Germany~~ Maryland

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Isabelle Weis
(b) Address 1019 Light St.

17 (a) Burial (b) Date thereof May 29, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director John F. Dingus, Inc.
(b) Address 715 Light St.

19 (a) MAY 29 1945 (b) Clayton Williams M.D.
(Date received by City Registrar) (Signature of Registrar)

VS 151

MEDICAL CERTIFICATION 10 30 A.M.

20. DATE OF DEATH May 24, 1945, at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Fractures, Ribs

Due to

Other Conditions Pulmonary emphysema, contused
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 24 1945 ? M.
(b) Where did injury occur? 1019 Light St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall in back yard?

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 25th 1945

(over)

G29276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G29276

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1514 Division St.
(b) Street address ~~1514 Division St.~~
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo. 4
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 W Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 9 Mos. | If less than one day 9 hr. 54 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Howard
13. Birthplace Cleveland Ohio

MOTHER
14. Maiden Name Helen Lacey
15. Birthplace Berhill, Pa

16 (a) Informant Helen Howard
(b) Address 620 W. Fairmount

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 29 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1945 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1945 to 5/25 1945 and that I last saw alive on 19

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Lewis M.D.
Address 1137 Harlem Ave Date signed 5/27/45

2128

X

G29277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

G29277 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calverts St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Miss Mildred Cozetta Hurd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 8 1922

8. AGE: Years 22 | Months 3 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Housekeeping

11. Industry or business

FATHER
12. Name Eugene H. Hurd
13. Birthplace Virginia

MOTHER
14. Maiden Name Lennie Price
15. Birthplace South Carolina

16 (a) Informant

(b) Address

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)

(c) Cemetery or crematory
Location [illegible] MAY 28 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 29 1945 Huntington Williams M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to May 27 1945 and that I last saw h alive on May 27 1945.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Peritonitis

Due to Volvulus of Sigmoid

Other Conditions Pregnant (Stillborn) 7 mo. of gestation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. K. Dunning, M.D.
Address U. M. Hosp Date signed 5/28/45

VS 150

2729 X

CW G29278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G29278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Cawl Court
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Mealor

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18, 1945

8. AGE: Years	Months	Days	If less than one day
			4 hr. 13 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Albert G. Mealor
13. Birthplace Georgia

MOTHER
14. Maiden Name Mary Frances Henley
15. Birthplace Georgia

16 (a) Informant.....
(b) Address.....

17 (a).....(Burial, cremation, or removal) (b) Date thereof.....(month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL MAY 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 MAY 29 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

2130

X

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945 to May 18 1945, and that I last saw him alive on May 18 1945

Immediate cause of death Prematurity

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature M. L. Griffith M. D.

Address Johns Hopkins Hospital Date signed 5-21-45

G29279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G29279

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3918 Gilston Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 Gilston Drive (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Miskell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married,~~ widowed, or divorced: Widow

6 (b) Name of ~~husband~~ or wife: L B. Miskell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24-1865

8. AGE: Years 79 | Months 9 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Neilill
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace Ireland

16 (a) Informant Mary Mauz
(b) Address 3918 Gilston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30-45 (mo.) (day) (year)
(c) Cemetery or crematory Mem. Cath.
Location Old Frederick Rd

18 (a) Funeral director John G Moran
(b) Address 3000 E Baltimore St

(Date received) MAY 29 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26, 19 45, to May 26 19 45, and that I last saw her alive on May 26, 19 45.

Immediate cause of death	Duration
Cerebral arteriosclerosis	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cavagnaro M. D.
Address 5 W Druid Park Lane Date signed 5/28/45

X

VS 150

G29280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29280 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 S. Stricker St
(c) Hospital or institution: — 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 S Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Fitzwater

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ina D. Fitzwater

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1-1875

8. AGE: Years 69 | Months 7 | Days 24 | If less than one day hr. — min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Ref. Machinist Helper

11. Industry or business B+O. R.R.

FATHER 12. Name Jacob Fitzwater

13. Birthplace Va.

MOTHER 14. Maiden Name Sarah A. Emswiler

15. Birthplace Va

16 (a) Informant Mrs. Ina D. Fitzwater

(b) Address 323 S. Stricker St

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)

(c) Cemetery or crematory Meadowridge Cem

Location Dorsey Md

18 (a) Funeral director Geo. L. Bayer Jr

(b) Address 1512 Hollins St.

19 (a) MAY 29 1945 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1943, to 5/25 1945, and that I last saw him alive on 5/25 1945.

Immediate cause of death Arteriosclerotic cardiovascular disease

	Duration
Due to	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 2030 Wilkens Date signed 5/29/45

avg X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81a

Registered No. G29281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David [redacted] Salton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/43

8. AGE: Years	Months	Days	If less than one day
1 2	11	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hilliam Salton
13. Birthplace Carlise S. Carolina

MOTHER
14. Maiden Name Annie Mollick
15. Birthplace Eastern Shore Md

16 (a) Informant Annie M. Salton
(b) Address 2417 Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port

18 (a) Funeral director P. Brooks
(b) Address 1463 N. Carey St

Date received MAY 29 1945 (b) Signature for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 12:38 a

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumococcus Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Williams M.D.
Medical Examiner.
Date signed 5-26-45

G29282 3 DRANGHAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168 Registered No. G29282

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 768 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 768 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Draughan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22 1898

8. AGE: Years	Months	Days	If less than one day
46	9	3	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Harrell
13. Birthplace Va

MOTHER
14. Maiden Name Evelyn Jenkins
15. Birthplace Va

16 (a) Informant Joseph Harrell
(b) Address 102 South St Portsmouth Va

17 (a) Removal (b) Date thereof May 29 / 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Portsmouth Va

18 (a) Funeral director Mrs. Lotsie A Elliott Dft.
(b) Address 129 N. Franklin St.

19 MAY 29 1945 Transcribing for Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1945, at 3:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/25/45 Found 2:30 P. M.
(b) Where did injury occur? 768 W. Mulberry St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Throttled

23. Signature Robert L. Gratton M.D.
Medical Examiner.
Date signed [redacted] May 26 1945

G29283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G29283

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Dickerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-82

8. AGE: Years 62 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace Virginia

MOTHER
14. Maiden Name Nannie Power
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave Huntington Williams Park, Md.

MAY 29 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 7:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1945 to May 27 1945 and that I last saw h[illegible] alive on May 27 '45

Immediate cause of death: Heart failure — Duration

Due to: Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of kidney

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus, M. D.
Address Johns Hopkins Hosp. Date signed 5/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1313

G29284 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Skinner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1889

8. AGE: Years 56 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name John Skinner
13. Birthplace D. C.

MOTHER
14. Maiden Name Floyd Waters
15. Birthplace Md

16 (a) Informant Miss Elizabeth Skinner
(b) Address 1405 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Comm
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances I. Hemsley
(b) Address 578 W. Biddle St.

19 (a) [illegible] (b) Huntington Williams M.D.
MAY 29 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945, at 2:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1945, to 5/28 1945, and that I last saw h[illegible] alive on 5/28 1945

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Woodland

Address Provident Hospital Date signed 5/29/45

X

G29285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30a

Registered No. G29285

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ethel Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Trappe, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location [redacted]

18 (a) Funeral director Elroy E. Walton
(b) Address 1000 Brantley Ave

MAY 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 45 to May 25 45 and that I last saw him alive on May 25 45

Immediate cause of death PRESUMPTIVE Circulatory Failure — Duration

Due to Myocardial Insufficiency

Due to Syphilitic Aortic Insufficiency

Other Conditions CNS SYPHILIS TABES DORSALIS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Graham G. Vance M.D.

Address Johns Hopkins Hospital Date signed 5/29/45

For S.C.J. Zubkoski, by Howard F. Andrews, M.D. 9/E

G29286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29286

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 - Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 61 | Months July | Days 24 | If less than one day hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Dance mstr

11. Industry or business

FATHER 12. Name Henry Carter
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Jennie Smith
15. Birthplace Frederick Co. Md

16 (a) Informant Norman Smith
(b) Address 826 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West port Md

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Monroe St.

19 MAY 29 1945 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26-1945 at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1945 to 5-26 1945 and that I last saw her alive on 5-24 1945

Immediate cause of death	Duration
Hypostatic pneumonia Cardio-renal disease - Uremic Coma	1 yr. 2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. T. Jacques

Address 630 Arlington Ave Date signed 5/28/45

VS 150

G29287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

89a

Registered No. G29287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died in

(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1540 N. Appleton St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME SARAH KARASIK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Ellis Karasik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph

13. Birthplace Russia

MOTHER 14. Maiden Name Rosa

15. Birthplace Russia

16 (a) Informant Ellis Karasik

(b) Address 1540 N. Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)

(c) Cemetery or crematory Workman Circle

Location Hebrew Mt Carmel Cem Lewis Inc

18 (a) Funeral director Isaac Lewis Inc

(b) Address 1429 E. Balto St

19 MAY 29 1945 Huntington Williams M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH V-28 1945, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1945 to 5/28 1945, and that I last saw her alive on 5/28 1945.

Immediate cause of death Renal insufficiency

Due to Sulfa crystal nitrosis with Resulting Anuria

Due to Pyelitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/27/45

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lucien Amelle M. D.

Address Sinai Hosp. Date signed 5/28/45

VS 150

G29288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G29288

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1648 Morland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md County

(b) City or town Baltimore (If outside city or town limits, write RURAL and name town)

(d) Street No. 1648 Morland Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Whitman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel

13. Birthplace Russia

MOTHER 14. Maiden Name Esther

15. Birthplace Russia

16 (a) Informant David Whitman

(b) Address 771 Wash. Blvd.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)

(c) Cemetery or crematory Wash. Blvd.

Location

18 (a) Funeral director Jos Levin Inc

(b) Address 1439 E. Balto. St

19 (a) MAY 29 1945 (Date rec'd by Registrar) (b) Certificate for Williams M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH V- 29- 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1921, to May 28 1945, and that I last saw h er alive on May 28 1945

Immediate cause of death	Duration
Acute heart failure	20 min
Due to Myocardial infarction	3 days
Due to Coronary Artery disease	2 yrs
Other Conditions Arterio sclerosis	25 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jacob Cohen M. D.

Address 1804 Eutaw Place Date signed 5/29/45

VS 150

G29289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No. G29289

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 54yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Samet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mollie Samet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Ret.
11. Industry or business

FATHER
12. Name Jacob -
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant Charles Samet
(b) Address 3125 Oakfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-45 (month) (day) (year)
(c) Cemetery or crematory Mount Kisloch Cem
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 143 E. Balto St

MAY 29 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945 at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 1945 to 5/28 1945, and that I last saw h[illegible] alive on 5/26 1945.

Immediate cause of death Edema
of pulmonary edema.

Due to Kidney calculi, hydronephrosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 3 Sinai Hosp Date signed 5/28/45

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G29290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert + Saratoga Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 St Paul St. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Persis P. Browne

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1895

8. AGE: Years 50 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER 12. Name Eli H. Browne

FATHER 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Jessie E. Archibald

MOTHER 15. Birthplace Baltimore, Md.

16 (a) Informant Persis Browne

(b) Address Above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Location Pikesville, Balto Co.

18 (a) Funeral director John Mitchell Sons

(b) Address 100 Eutaw Place

19 (a) MAY 29 1945 (Date rec'd by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1945 to 5/28 1945, and that I last saw her alive on 5/28 1945.

	Duration
Immediate cause of death Respiratory failure	1 hr
Due to Carcinoma of cervix & metastasis	10 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 1944

Major findings of operation: Ca. of cervix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Hohenemann M.D.

Address Mercy Hospital Date signed 5/28/45

VS 150

G29291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G29291

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1944

8. AGE: Years | Months 7 | Days | If less than one day hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Hazel Carroll
15. Birthplace Md

16 (a) Informant Hazel Carroll
(b) Address 1939 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. D. Kelso
(b) Address 1303 Pennsylvania Ave

19 MAY 29 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 19 45 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 5/29/45

VS 151

(over)

G29292

J1 - 93552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29292 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Lancaster St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard H. Fuller or Robert H. Fuller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1886

8. AGE: Years 59 | Months 3 | Days 11 | If less than one day ..hr. ..min.

9. Birthplace Maine
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard H.
13. Birthplace Maine

MOTHER
14. Maiden Name Hannah Roach
15. Birthplace Maine

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/37 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director
(b) Address

19 (a) MAY 29 1937 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1937, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5, 1937, to May 24 1937, and that I last saw him alive on May 24 1937

	Duration
Immediate cause of death: Perforated duodenal ulcer	24 hrs
Due to: Arteriosclerotic heart disease	?
Due to	
Other Conditions: Bleeding from G I Tract	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 5-28-37

G29293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G29293
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dunbar & Greene
(c) Hospital or institution: University 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Mat Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES O. IGLEHART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife "

6 (c) If alive, give age " years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation "

11. Industry or business

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant City Hosp.
(b) Address Eastern Av

17 (a) Burial (b) Date thereof 5/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director Wm. H. Armistead
(b) Address 1300 E. Fayette St

19 (a) MAY 29 1945 (b) Signature for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27/45 19..., at 6:25 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 5/28/45

G29294 G29294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH V 927

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 212 N. Glover St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Henry M. Ruth Sr. — If U. S. Veteran specify WAR

(a) Residence: No. 212 N. Glover St., Ward. (If non-resident give city or town and State)
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lavinia Croswell

6. DATE OF BIRTH (month, day, year) Nov 10 - 1879

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	6	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Dept of Agriculture

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME George Ruth

14. BIRTHPLACE (city or town) (State or country) Balto Md

MOTHER

15. MAIDEN NAME Mary McGinn

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Lavinia Ruth Wife
(Address) 212 N. Glover St

18. BURIAL, CREMATION, OR REMOVAL
Place Woodlawn Date May 31 1945

19. UNDERTAKER Frank D. Wm Pipitone
(Address) 2818 E. Balto St

20. FILED MAY 29 1945 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 28, 1945

22. I HEREBY CERTIFY, That I attended deceased from April 23 1945 to May 28 1945

I last saw h alive on May 5, 1945. Death is said to have occurred on the date stated above, at 11 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Cardiac Dil.	1 day

Other contributory causes of importance:

Chr. Valvular Heart Dis.	11 years

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
... If so, specify ...

(Signed) C N Reyer M. D.

(Address) 1522 E 33rd St

X

G29295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

72a

G29295

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St.

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Chesaco Park, Balto. 6 Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 926 Chesaco Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Elaine W. Berk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4th. 1937

8. AGE: Years	Months	Days	If less than one day
8	3	24	hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation At School

11. Industry or business

FATHER

12. Name John George Berk

13. Birthplace Baltimore County, Maryland

MOTHER

14. Maiden Name Margaret E. Hoffmeister

15. Birthplace Baltimore County, Maryland

16 (a) Informant John George Berk

(b) Address 926 Chesaco Ave. Balto. 6 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31. 1945 (month) (day) (year)

(c) Cemetery or crematory Zion Lutheran Cem.

Location Stemmers Run, Maryland

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Road

19 MAY 29 1945 (Date rec'd by registrar) Herrington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/1945, at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1945, to 5/28 1945 and that I last saw her alive on 5/27 1945.

Immediate cause of death Cardio-Resp. failure — Duration

Due to Myocard. Insuff.

Due to Pulmon. Edema

Other Conditions Hemiplegia-Schizophrenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy: Generalized pulmonary Hemorrh.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed 5/29/45

STANLEY STEINBERG 93E

TAMBURRINO

G29296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G29296 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 S. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dave Tamburrino

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 28 1928

8. AGE: Years	Months	Days	If less than one day
17	2	29	hr. min.

9. Birthplace Mckeesport, Penn.
(Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Domenico Tamburrino
13. Birthplace Italy

MOTHER
14. Maiden Name Domenica Di Rocco
15. Birthplace Italy

16 (a) Informant Domenico Tamburrino (Father)
(b) Address 402 S. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Ceme.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

MAY 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27-45 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-27-45 at 4/1 11.30 A.M.
(b) Where did injury occur? City Harbor, Pier 6 Boat Slip
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from a Concrete Walk.

23. Signature Howard A. Clendenin M.D.
Medical Examiner.
Date signed 5-28-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 372 Forrest St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 372 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margherita Inzerillo

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~of wife~~ late Biaggio Inzerillo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. ? 1872

8. AGE: Years	Months	Days	If less than one day
72	9		hr. min.

9. Birthplace Castelvetrano Italy
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Andrea Faccetta
13. Birthplace Italy

MOTHER
14. Maiden Name Nicolina Di Giorgio
15. Birthplace Italy

16 (a) Informant Andrew Inzerillo (Son)
(b) Address 372 Forrest St.

17 (a) Burial (b) Date thereof June 1st/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

MAY 29 1945 (b)
(Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1945, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1942 to May 29, 1945, and that I last saw her alive on May 28, 1945

Immediate cause of death	Duration
Congestive Heart Failure	4 days
Due to Chronic Myocarditis	Unknown
Arteriosclerosis	Unknown
Due to Chronic Naphritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ehilard Artigiani M. D.
Address 2942 E. Fayette St. Date signed 5/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29298 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 962 Armistead Walk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Price

3 (b) If veteran, name war

3 (c) Social Security Account No. 063-09-5361

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Kathleen Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1904

8. AGE: Years 40 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Brooklyn, N.Y.
(Town, county, and state)

10. Usual Occupation Asst Supervisor

11. Industry or business Social Security

FATHER 12. Name George Price

13. Birthplace Brooklyn N.Y.

MOTHER 14. Maiden Name Elizabeth Sague

15. Birthplace Brooklyn N.Y.

16 (a) Informant Kathleen Price (Wife)

(b) Address 962 Armistead Walk

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 29/45 (month) (day) (year)

(c) Cemetery or crematory St Johns Cemetery

Location Richmond Hill N.Y.

18 (a) Funeral director Williams Cook Inc

(b) Address 1219 St Paul St

MAY 29 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed 5-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 S. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank W. Timms

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-12-1885

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna E. Timms

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 16 1892

8. AGE: Years	Months	Days	If less than one day
53	1	12	hr. min.

9. Birthplace Stevensville Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Phx Bldg Co

FATHER 12. Name Wm H Timms

13. Birthplace Md

MOTHER 14. Maiden Name Minnie L. Harris

15. Birthplace Md

16 (a) Informant Anna E. Timms

(b) Address 718 S. Fulton Ave

17 (a) Burial (b) Date thereof May 31 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Stevensville Cem

Location Stevensville Md

18 (a) Funeral director Pratt C. B. M. Walter

(b) Address Pratt & Stricker Sts

19 (a) MAY 29 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to May 28 1945; and that I last saw him alive on May 27 1945.

Immediate cause of death Coronary Thrombosis sudden death — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas D. Schreiber M. D.

Address 548 Fulton Ave Date signed 5-27-45

VS 190

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G29300

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves

(c) Hospital or institution: St. Agnes Hospital W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2345 Eutaw Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Regina B. Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-39

8. AGE: Years 6 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name William Bowers

13. Birthplace Pa.

MOTHER 14. Maiden Name Regina Townsley

15. Birthplace Md.

16 (a) Informant Regina B. Bowers

(b) Address 2345 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-1945 (month) (day) (year)

(c) Cemetery or crematory Woodbridge Bend

Location Howard Co Md

18 (a) Funeral director Pott & B.M. Walter

(b) Address Pott & Sheeler Sts

19 (a) MAY 29 1945 (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1945 to 5-28 1945 and that I last saw her alive on 5-28 1945

Immediate cause of death Toxaemia

Due to 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

—

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 45

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 5-9-45 at M

(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no

(e) Means of injury burned by matches

23. Signature Howard J. Sheeler M.D.

Address St Agnes Hosp Date signed 5/28/45

For B.H.B. Title Nally, for Howard J. Sheeler, M.D. X

G29301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1101

Registered No. G29301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 86 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 86 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frederick W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13-1864

8. AGE: Years 80 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Christian Walther
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Lillian G. Little
(b) Address 2038 Griffith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem
Location Balto Co. B.M. Walther

18 (a) Funeral director
(b) Address Pratt & Fruckers St

19 (a) (Date rec'd by registrar) By Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to May 29 1945.
and that I last saw h alive on May 29 1945.

Immediate cause of death Auricular Fibrillation — Duration 1 year

Due to

Due to

Other Conditions Pleurisy. — 2 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 517 Scott St Date signed 5/29/45 M. D.

VS 150

95a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29302

BALTIMORE CITY HEALTH DEPARTMENT

HOLLINS

CERTIFICATE OF DEATH

109

G29302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Talbot & Saratoga sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 863 W Fayette st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Hollins
3 (b) If veteran, name war W
3 (c) Social Security Account No. none
4. Sex M.
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married 36
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 67 Months Days If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Arthur J. Hollins
13. Birthplace England

MOTHER
14. Maiden Name Mary Robbins Flynn
15. Birthplace Maryland

16 (a) Informant Mrs. George Robinson
(b) Address 3503 Oakmont Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/30/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland
18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street
19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MAY 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to May 28 1945, and that I last saw h[illegible] alive on May 28 1945

Immediate cause of death acute pulmonary edema — Duration

Due to Cardiac failure

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Pelton M. D.
Address Mercy Hosp. Date signed 5/30/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29303
AB-93537

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107 ✓ Registered No. G29303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 Vine St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Kidd

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5- 1894

8. AGE: Years 51 | Months 3 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ray Kidd (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Annie V. Mitten (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals(Records) Address 4940 Eastern Ave.

17 (a) Buried (b) Date thereof 5/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden, Baltimore Md

18 (a) Funeral director Fallon Funeral Home Inc
(b) Address 1214 E Fort Ave

19 (a) MAY 29 1945 (b) [illegible] Registrar M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9- 1945, to 5-28 1945, and that I last saw h im alive on 5-29- 1945.

Immediate cause of death Coma - Duration Days
Pneumonia

Due to

Due to

Other Conditions Paralysis agitans Hx. Arteriosclerosis 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Aut.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E M Rudolph M. D.
Address Baltimore 4501 Date signed 5-28-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29304 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 McHenry Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 McHenry Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Leah R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-31-1870

8. AGE: Years 74 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Rhein Pa.
(Town, county, and state)

10. Usual Occupation Laboratory assist
11. Industry or business City of Balto

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Leah R. Young
(b) Address 1805 McHenry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard J Rinde
(b) Address 5305 Sanford Rd

19 MAY 29 1945 (b) Huntington Williams, Balto

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1945, to 2/22 1945, and that I last saw him alive on 5/22 1945.

Immediate cause of death	Duration
Cardio Vascular Renal	3 m
Due to arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. J. Sanders M. D.
Address 100 N Miller St Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29305

4740 46

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49a

Registered No. G29305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Ridgecroft Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice A. Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed.

6 (b) Name of husband or wife Williard O. -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18-77

8. AGE: Years	Months	Days	If less than one day
67	8 9	10	hr. min.

9. Birthplace Allentown Pa (Town, county, and state)

10. Usual Occupation none.
11. Industry or business at home

FATHER
12. Name Frank Stephen Young
13. Birthplace Pa.

MOTHER
14. Maiden Name Lucetta Elizabeth Kreagey.
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ryck
(b) Address 530 S Harford St

19 (a) MAY 29 1945 (Date received by registrar) (b) Transcribed by Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 28 1945, at 10.19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May. 18 1945 to May-28 1945, and that I last saw her alive on May-28 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Carcinomatosis	
Due to Carcinoma Ovary	
Other Conditions Intestinal Obstruction (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Generalized Carcinoma
of autopsy: Peritoneum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Rustedy M. D.
Address Johns Hopkins Hosp. signed 5/28/45

X

G29306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G29306 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 565 Woodbine Ave. Towson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Horn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-22-45

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mr. Frank W. Horn
13. Birthplace

MOTHER
14. Maiden Name Miss Alice Rike
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Kept for
Location Scientific purposes

18 (a) Funeral director W. M. Hospital
(b) Address

19 MAY 29 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1945 at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1945 to 5-22 1945 and that I last saw h~~im~~ alive on 5-22 1945

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Congenital Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adelaide Spraguine

Address U. M. H. Date signed 5-24-45

VS 150

G29307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G29307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Oakland Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Leaks (PEAKS)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 10 hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Byron Peaks
13. Birthplace Virginia

MOTHER
14. Maiden Name Bertha Peaks
15. Birthplace Virginia

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL MAY 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) MAY 29 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945, at 11:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3-1945 to ..... 19..., and that I last saw h..... alive on 5-21-1945.

Immediate cause of death Hemorrhagic Disease of the Newborn

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Warren C. Weirsath M.D.
Address J.H.H. Date signed 5-22-45

12:32 Warren C. Weirsath M.D.

G29308 BALTIMORE CITY HEALTH DEPARTMENT G29308
CERTIFICATE OF DEATH 107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4623 Schenley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4623 Schenley Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Susan Clara Dawson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles E. Dawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1862

8. AGE: Years 82 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas Carp
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances J. Devinney
15. Birthplace Maryland

16 (a) Informant Charles E. Dawson
(b) Address 4623 Schenley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) MAY 29 1945 (Date rec'd by registrar) (b) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 12:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1945, to May 28 1945, and that I last saw h[illegible] alive on May 28 1945.

Immediate cause of death Bronchial Pneumonia — Duration 4 Hours
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Gibson Porter
Address 1166½ N. Eutaw St. Date signed 5/29/45 M. D.

VS 150

G29309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.o.H
(b) Street address 1415 E. Clement St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 E. Clement St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Seepe (Sapi)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married.

6 (b) Name of husband or wife. John Sapi.
(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Dec 20th 1862

8. AGE: Years	Months	Days	If less than one day
82 81	5	8 7	hr. min.

9. Birthplace Hungary.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph Turansky
13. Birthplace Hungary

MOTHER
14. Maiden Name Julia Barany.
15. Birthplace Hungary.

16 (a) Informant Mrs Elizabeth Clark.
(b) Address 1302 Hanbert St.

17 (a) Burial (b) Date thereof May 30th 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore

18 (a) Funeral director Charles F. Dill.
(b) Address 1501 E Fort Ave

19 (a) May 29 1945 Huddington Williams Registrar
(Date received) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 6 00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Ludwick M.D.
Medical Examiner.
Date signed 5-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 54 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 54 S. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Schmitt

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anne E. Schmitt

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Jan. 11, 1887

8. AGE: Years 58 | Months 4 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Plumber

11. Industry or business: Self

FATHER
12. Name: Rudolph Schmitt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Stengler
15. Birthplace: Germany

16 (a) Informant: Mrs Anne E. Schmitt
(b) Address: 54 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30, 1945 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn P.O.

18 (a) Funeral director: Frederick A. Dole
(b) Address: 2000 W. Lombard St.

19 (a) 5-29-1945 (Date received by registrar) (b) ... Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1945, at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to May 26 1945, and that I last saw h[illegible] alive on May 26 1945.

Immediate cause of death: Rheumatic Conditi[illegible] — Duration: ?

Due to: -

Due to: -

Other Conditions: Coronary Thrombosis — Duration: about 1 yr.

(Include pregnancy within 3 months of death)

Date of operation: -

Major findings of operation: -

of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: -
(b) Date of occurrence: - at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: H. Rokhreeter M. D.
Address 54 S. Fulton Ave Date signed 5-28-45

58 D

G29311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

Registered No. G29311

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County Baltimore
(c) City or town Sandusky (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

Balto. Address

3 (a) FULL NAME [redacted] Williams (Elaine)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: William Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 34 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace Pittsburgh Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name A. B. Roe
13. Birthplace Ohio

MOTHER
14. Maiden Name Gertrude Rowe
15. Birthplace Pa

16 (a) Informant Mr. William Williams
(b) Address Athens Ohio

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/29/45 (month) (day) (year)

(c) Cemetery or crematory
Location Athens Ohio

18 (a) Funeral director Geo. E. Boyer Jr
(b) Address 1512 Hollins St

19 (a) MAY 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 1945 to 5/28 1945 and that I last saw h[illegible] alive on 5/28 1945

Immediate cause of death	Duration
Acute Pulmonary Edema	5 hrs
Due to Probable Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.

Address Md. Gen'l Hospital Date signed 5/29/45

X

G29312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G29312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3516 Park Dale ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-8
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 Park Dale ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Russel E. Riley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-7819

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11 1881

8. AGE: Years 63 Months 6 Days — If less than one day hr. min.

9. Birthplace Rock Springs, Cecil, Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Textile Mill

FATHER
12. Name Kennard Riley
13. Birthplace Rock Springs, Md

MOTHER
14. Maiden Name Anna E. Cruikshank
15. Birthplace Bethel, Pa.

16 (a) Informant Estella Bailey
(b) Address Perryville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Union
Location Hattingham Va. Rural

18 (a) Funeral director Wm. A. Patterson & Son
(b) Address Perryville, Md

19 MAY 30 1945 Filed Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1945 to May 27 1945 and that I last saw h— alive on May 27 1945.

Immediate cause of death Coronary Thrombosis — Duration ?
and Cardiac Insufficiency
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel L. Grim M. D.
Address 176 E. Main St. Date signed 5/29/45

VS 150

G29313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G29313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2042 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Max Kessler (KARASOFF)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Max
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia.

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V-30-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pratt Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 439 E. Balto St.

19 (a) MAY 30 1945 (Date received by Local Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 1945; at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1945 to 5-/29 1945, and that I last saw h alive on 5/29 19 45.

Immediate cause of death C-R failure
Carcinoma ? ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. D. Scherlis M.D.
Address Sinai Hospital Date signed 5/29

X

G29314 ✓ G29314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 W. Lexington St.
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie B. Davis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Joseph Davis
(c) If give, give age years
7. Birth date of deceased (mo., day, yr.) Apr 1883
8. AGE: Years 62 | Months 1 | Days | If less than one day hr. min.
9. Birthplace Clinton, Tenn (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Thomas Jefferson
13. Birthplace N. C

MOTHER
14. Maiden Name Unknown
15. Birthplace Tenn

16 (a) Informant Lamar E. Davis
(b) Address 743 W. Lexington St.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 30. 1945 (month) (day) (year)
(c) Cemetery or crematory Sunset Cem
Location Clinton, Tenn
16 (a) Funeral director Sun-Nes. John W. Teufel & Son
(b) Address 101 N. Fayette St
19 MAY 30 1945 (Date rec'd by Registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945 at 6 15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to May 27 1945 and that I last saw her alive on May 27 1945.

Immediate cause of death: Cardiac Carcinoma — Duration
Due to: Hepatomas
Due to: Cachexia
Other Conditions: None
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos Rosemann MD M. D.
Address 715 N Paca Date signed 5/29/45

YS 150

G29315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29315

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry E. Purnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Widowed

6 (b) Name of husband or wife EMMA (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1874

8. AGE: Years	Months	Days	If less than one day
70	10	15	hr. min.

9. Birthplace BALTO., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Purnell
13. Birthplace Md

MOTHER
14. Maiden Name Roxanna Weaver
15. Birthplace Md

16 (a) Informant ERVA FRANCIS
(b) Address 738 DOLPHIN ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/45 (month) (day) (year)
(c) Cemetery or crematory MT. AUBURN
Location

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 536 N. Central Ave

MAY 30 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27 1945 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945, to May 27, 1945; and that I last saw h alive on May 27 1945.

Immediate cause of death Cardio-Renal Arteriosclerosis

Duration
?
?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Harrison M. D.
Address 1074 Cathedral Date signed 5/29/45

G29316 Henry V. Lucas G29316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Har Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 W. Monument St. (If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME Henry V. Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---

8. AGE: Years	Months	Days	If less than one day
About 63	---	---	-- hr. -- min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Estimator
11. Industry or business Building

FATHER
12. Name ------ Lucas
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Louise E. Espenschied
15. Birthplace Germany

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/45 (month) (day) (year)
(c) Cemetery or crematory Belfontaine
Location St. Louis, Mo.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

19 (a) MAY 29 1945 (Date received by registrar) Huntington Wilt Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 1945, at 1:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/25 1945 to 5/29 1945, and that I last saw h[illegible] alive on 5/29 1945

Immediate cause of death	Duration
C-R failure.	
Due to Uremia.	
Due to Bladder tumor	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Generalized Ca.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dr. [illegible] M.D.
Address Sinai Hospital Date signed 5/30/45

X

G29317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G29317

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3437 Edmondson Ave.
(c) Hospital or institution:
20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3437 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA REBECCA SEWARD

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Timothy W. Seward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 14, 1865

8. AGE: Years	Months	Days	If less than one day
79	10	14	hr. min.

9. Birthplace: Queen Anne Co., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Clannahan
13. Birthplace: Queen Anne Co., Md.

MOTHER
14. Maiden Name: ?
15. Birthplace: Queen Anne Co., Md.

16 (a) Informant: Mrs. Alice Baxter
(b) Address: 3437 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 30 1945 (Date rec'd by registrar) (b) Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to May 1945, and that I last saw him alive on May 26 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Chronic Nephritis

Due to: Cardio-Vascular Hypertension

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Leander R. Heyman M.D.

Address: 5328 York Rd. Date signed May 31, 1945

VS 150

G29318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G29318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 Wildwood Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Wildwood Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Margaret T Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1882

8. AGE: Years	Months	Days	If less than one day
62	8	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thos Murphy
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Deering
15. Birthplace Ireland

16 (a) Informant Miss Mary Murphy
(b) Address 513 Wildwood Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Burge & Tipton
(b) Address Fulton Ave & Lafayette

19 (a) MAY 30 1945 (Date rec'd by registrar) Huntington Williams Asst. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1935, to May 29 1945, and that I last saw her alive on May 28 1945.

Immediate cause of death Carcinoma Stomach — Duration ?

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Morris B. Schreibe, M.D. M. D.

Address Date signed

G29319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G29319

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Archentorally Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Rebecca Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
Female	White	

6 (b) Name of husband or wife: Wilson D. Waters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1861

8. AGE: Years	Months	Days	If less than one day
83	8	26	hr. min.

9. Birthplace: Calvert County, Md.
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Octavus W. Bowen
13. Birthplace: Calvert Co., Md.

MOTHER
14. Maiden Name: Rebecca E. Woods
15. Birthplace: Calvert Co., Md.

16 (a) Informant: Mrs. Alice A. Link
(b) Address: 3530 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)
(c) Cemetery or crematory: Waters Mem. Cem.
Location: Calvert Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 30 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/29/1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18/1945 to 5/29/1945, and that I last saw her alive on 5/28/1945

Immediate cause of death: Lobular Pneumonia, Left — Duration

Due to

Due to

Other Conditions: Thrombosis & hemorrhage of post cerebral vessels, ant.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobular Pneumonia, Thrombosis of Cerebral Vessel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Charles E. Shaw Jr. M. D.
Address: Md. Gen'l Hosp'l. Date signed: 5/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G29320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2424 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 N Presbury St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Coplan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca Copland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Russia (town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Benj. Coplan
13. Birthplace: Russia

MOTHER
14. Maiden Name:
15. Birthplace: Russia

16 (a) Informant: Mrs. Rebecca Coplan
(b) Address: 2424 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-45 (month) (day) (year)
(c) Cemetery or crematory: Russedale
Location:

18 (a) Funeral director: Jack Meyer Inc
(b) Address: 139 E. Balto. St

19 (a) Date received: MAY 30 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30/45 19 ... at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 ... to 5/30 19 45. and that I last saw h[illegible] alive on 5/29 1945.

Immediate cause of death: Coronary thrombosis, arteriosclerosis — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Huntington Williams

Address: 904 Reisterstown Rd Date signed: 5/30/45

VS 150

G29321 ✓ G29321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 N. Bouldin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Bouldin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Buppert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8, 1858

8. AGE: Years	Months	Days	If less than one day
87	1	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name John C. Wolf.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Mrs. Whittle Daughter
(b) Address 610 N. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery.
Location Randallstown Md

18 (a) Funeral director L. Walter May.
(b) Address 619 N. Bouldin St.

MAY 30 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945, at 6.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944 to May 28 1945, and that I last saw h[illegible] alive on May 27 1945.

Immediate cause of death: myocardial insufficiency — Duration 2 days
Due to: senility, cerebrosis. Cachexia
Due to:
Other Conditions: arterio-sclerosis, chr. nephritis — 3
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Bottleal
Address 447 N. Kenwood Ave. Date signed 5/30/45

925

G29322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G29322

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret A. Dunphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	W.

6 (b) Name of husband or wife Joseph P. Dunphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3 1859.

8. AGE: Years	Months	Days	If less than one day
85	7	25	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name Bernard McIntosh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Connolly
15. Birthplace Ireland

16 (a) Informant Edward Considine
(b) Address 528 W Mulberry St.

17 (a) Burial (b) Date thereof 5/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. D. Grant & Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) MAY 30 1945 (b) Huntington Willi Registrar, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945, at 8 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13/ 1945, to 5/28 1945, and that I last saw h.e.r. alive on 5/28 1945.

Immediate cause of death Extreme Cachexia & Metastasis — Duration: 2 Wks.

Due to Carcinoma of Rectum — Duration: Years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Mar 14 & May 8/45.

Major findings of operation: Chr. Cholecystitis Ext. Obstruction; Ca of Rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Messenger M. D.
Address Mercy Hosp. Date signed 5/28/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G29323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No. G29323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale Home
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Moreland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Sodden

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-22-1287

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Brush Factory

FATHER
12. Name: Samuel Sodden
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ethel Stein
15. Birthplace: Russia

16 (a) Informant: Lena Sodden
(b) Address: 1608 Moreland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 30, 1945 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) MAY 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-30 1945, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16- 1945 to 5-30 1945 and that I last saw h. in alive on 5-30 1945

Immediate cause of death	Duration
Tbc. of spine	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. Edmund Levin M.D.

Address: Levindale Date signed: May 30 1945

G29324

BALTIMORE CITY HEALTH DEPARTMENT (aw) 93d

CERTIFICATE OF DEATH

Registered No. G29324

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Andrew

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Louisa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/1866

8. AGE: Years 79 | Months 4 | Days 2627 | If less than one day hr. min.

9. Birthplace Glasgow Scotland (town, county, and state)

10. Usual Occupation Conductor, Railroad

11. Industry or business

FATHER
12. Name David M Andrew
13. Birthplace Scotland

MOTHER
14. Maiden Name Sarah A Mahoney
15. Birthplace Scotland

16 (a) Informant Mrs Charles Phillips
(b) Address 300 E. 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery Balto
Location Baltimore Md.

18 (a) Funeral director Wilhoyte
(b) Address 1211 E Fayette St

19 (a) May 30, 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 2d

20. DATE OF DEATH 5/30/1945; at 12 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Mahaffey M.D. Medical Examiner.
Date signed 5/30/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

629325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 B

Registered No. 629325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Light St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Light St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Cleveland Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura T. Bell

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) June 2 1884

8. AGE: Years 60 | Months 11 | Days 18 | If less than one day: hr. min.

9. Birthplace Bedford Va (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business W. Md. R.R.

FATHER 12. Name Henry Bell

13. Birthplace Va.

MOTHER 14. Maiden Name Rose Kinzer

15. Birthplace Bedford Va

16 (a) Informant Mrs Laura T. Bell

(b) Address 1526 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1-1945 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cem.

Location Hagerstown Md.

18 (a) Funeral director Willis Lowe Funeral

(b) Address 1510 Liberty Hgts Ave

19 (a) MAY 30 1945 (Date rec'd by registrar) (b) Huntington-Williams, M.P.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 1:45 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1945, to 5/30 1945, and that I last saw him alive on 5/29 1945.

Immediate cause of death: Carcinoma of tongue with metastasis to glands into neck. — Duration: 2,

Due to —

Due to —

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Bell

Address 1526 Harlem St. Date signed 5/30/45

VS 150

X

G29326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G29326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Bouldin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Naughton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ellen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/1910

8. AGE: Years	Months	Days	If less than one day
35	1	22	hr. min.

9. Birthplace IRELAND
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Paul Jones Dist'y

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ellen Naughton, wife
(b) Address 517 S. Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Tilly & Sons Inc.
(b) Address 403 S. Wolfe Street

19 (a) MAY 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive 3rd & 2nd degree burns

Fracture of skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 28 1945 9:45 A.M.
(b) Where did injury occur? 200 Kresson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury steam pipes exploded

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed May 28 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29327 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 S. Bouldin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 337 S. Bouldin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emelia Krause

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John A Krause

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1865

8. AGE: Years 79 | Months 80 | Days 8 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Anna Wesley Stanley

(b) Address 337 S Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 1945 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location

18 (a) Funeral director John J. Connelly

(b) Address 418 Eastern Ave

19 (a) MAY 30 1945 (Date of death) (b) Huntington Williams, M.D. (Signature of attending physician)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1945, at 2:04 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1940, to 5/24 1945, and that I last saw her alive on 5/24 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 10 yrs.

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard V. Williams M. D.

Address 3735 Eastern Ave. Date signed 5/28/45

Maniert

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

629328 178a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Roanoke (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Coleman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1905

8. AGE: Years	Months	Days	If less than one day
40	3	1	hr. min.

9. Birthplace Lynchburg, Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Gibbs Cannery Co

FATHER
12. Name George Coleman
13. Birthplace unk

MOTHER
14. Maiden Name Ida Green
15. Birthplace Lynchburg, Va.

16 (a) Informant Diuguid Funeral Home
(b) Address Lynchburg Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-45 (month) (day) (year)

(c) Cemetery or crematory
Location Lynchburg Va

18 (a) Funeral director Fredricke A. Diuguid
(b) Address 1200 N. Lombard St

19 (a) (b)
(Signature of registrar) Registrar

MAY 31 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 9:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to Carbon Monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 29 1945 - 18/3 9 A.M.
(b) Where did injury occur 871 Holland St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas from stove

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 29 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G29329 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 495 Edgewater Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edna Dollens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: John J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1891

8. AGE: Years 54 | Months 3 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name James A. Barker

13. Birthplace Va.

MOTHER 14. Maiden Name Elizabeth Gouldman

15. Birthplace Md.

16 (a) Informant John J. Collins Jr.

(b) Address 495 Edgewater Apts. -24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)

(c) Cemetery or crematory

Location Richmond Va.

18 (a) Funeral director Martin Tabb & Sons

(b) Address 1827 W. North Ave.

19 (a) JUN 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 19 45, at 6.58 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 19 45 to 5/30 19 45 and that I last saw her alive on 5/30 19 45

Immediate cause of death Heart failure

Due to

Due to Spread of Carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.

Address 4 E. Eager St. Date signed 5/30/45

VS 150

629330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9/a

629330

Registered No. 57044

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mo5da

(e) Length of stay in Baltimore (yrs., mos., or days) 6mo, 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Penna (b) County

(c) City or town Philadelphia

(If outside city or town limits, write RURAL and give town)

(d) Street No. 216 Fernon Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rupsis, Simon Alfonse Casimir

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1921

8. AGE: Years	Months	Days	If less than one day
23	6	22	hr. min.

9. Birthplace Philadelphia, Pa.

(Town, county, and state)

10. Usual Occupation Ord seaman

11. Industry or business

FATHER

12. Name Simon Rupsis

13. Birthplace Lithuania

MOTHER

14. Maiden Name Pauline ?

15. Birthplace Lithuania

16 (a) Informant J. Karalaus[illegible]

(b) Address 1601 2nd St Phila

17 (a) Burial (b) Date thereof June 4-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location Phila Pa.

18 (a) Funeral director Joseph Kasiulis[illegible]

(b) Address 602 Washington Blvd

19 (a) (b) MAY 31 1945

(Date received by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 2.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/ 1944, to May 29 1945, and that I last saw him alive on May 29 1945.

Immediate cause of death	Duration
Rupture of Aorta	Terminal
Due to Subacute Bacterial Endocarditis of Aortic Valve	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James W. Dodd M. D.

Address U.S. Marine Hospital Date signed 5/30/45

X

629351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1823

Registered No. 629351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 785 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILMER K. CRAMBLETT Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10th 1943

8. AGE: Years	Months	Days	If less than one day
1	5	19	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilmer K. Cramblett
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Maude D. Lewis
15. Birthplace Balto. Md.

16 (a) Informant Wm K. Cramblett Sr.
(b) Address 785 Washington Blvd

17 (a) Burial (b) Date thereof 6/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington, Williamsport, Md.

MAY 31 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1945 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to canvas cord about neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/29/45 2 P. M.
(b) Where did injury occur? 785 Washington Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Cord tangled about neck

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 29 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 Aldershot Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM R. GARDINER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth M. Gardiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 5/2/1885

8. AGE: Years 60 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace: Winchester, Va.
(Town, county, and state)

10. Usual Occupation: Builder & Contractor

11. Industry or business: Self

FATHER
12. Name: Isaac J. Gardiner
13. Birthplace: Va.

MOTHER
14. Maiden Name: Emma Beam
15. Birthplace: Va.

16 (a) Informant: Mrs. Elizabeth M. Gardiner
(b) Address: 643 Aldershot Rd., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)
(c) Cemetery or crematory: Trinity Lutheran Cem.
Location: Taneytown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 31 1945 (Date received by registrar) (b) Huntington Willard, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29-45 19 , at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17-41 19 , to 5-29-45 19 , and that I last saw h[illegible] alive on 5-29-45 19

Immediate cause of death: Coronary Thrombosis — Duration: 2days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature (Harry S. Gambill)

Address 2703 Edmondson Ave. Date signed 5-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29333 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4208 Fernhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Fernhill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Tilden Herbert

3 (b) If veteran, name war: Spanish
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene R. Herbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1876

8. AGE: Years 68 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Charles Co., Md. (Town, county, and state)

10. Usual Occupation Capt. (Retired)

11. Industry or business Merchant & Miners Steamship Co.

FATHER
12. Name ? Herbert
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Johnson
15. Birthplace Md.

16 (a) Informant Mrs. Irene R. Herbert
(b) Address 4208 Fernhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Washington Williams, M.D.

19 (a) MAY 31 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 5/30 1945, and that I last saw him alive on 5/30 1945.

Immediate cause of death: Coronary thrombosis — Duration: acute
Due to: Arteriosclerotic heart disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Edward Leach, M. D.
Address 14 E. Eager St. Date signed 5/30/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29334 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katie Emrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis Emrich

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 10-8-1871

8. AGE: Years	Months	Days	If less than one day
73	7	21	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Sauerwald
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name
15. Birthplace Baltimore, Md

16 (a) Informant Donald F. Emrich
(b) Address 1926 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon-Park
Location Baltimore, Md

18 (a) Funeral director J. B. Wisheart & Son
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 31 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 19 45 at 1:43 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 19 45 to 5/29 19 45, and that I last saw her alive on 5/29 19 45.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St. Agnes Hosp Date signed 5/29/45

G29335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G29335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N. Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard W. Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-9869

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1907

8. AGE: Years	Months	Days	If less than one day
37	8	4	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business Bethlehem S. Yards

FATHER
12. Name James Campbell
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Lawrence
15. Birthplace Md.

16 (a) Informant Mary Campbell
(b) Address 203 N. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8 1945 (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Gaylor Ave

18 (a) Funeral director Leo B. Brooks
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAY 31 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945, at 10 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra Cranial Hemorrhage, Traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/26/45 at 5:2 7 P. M.
(b) Where did injury occur? Orleans & Forrest Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury. Slipped and fell from curb

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed May 28 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G29336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 S.Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 S.Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina Niemitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Albert L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.29,1858

8. AGE: Years	Months	Days	If less than one day
87	2	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name not known
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Edward Niemitz
(b) Address 912 S.Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1629 N.Broadway

19 (a) (Date received by registrar) MAY 31 1945 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 3.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to 19, and that I last saw h alive on May 26 1945.

Immediate cause of death	Duration
arteriosclerotic C.V. Disease	
Chr. Myocarditis	Jan 15/45
Due to Coronary Occlusion	5-22-45
Due to None.	
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. Niemitz M. D.
Address 912 E. Eastern Ave. Date signed 5-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29337 ✓ G29339

BALTIMORE CITY HEALTH DEPARTMENT

TN. 93895 CERTIFICATE OF DEATH 1172 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Dover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Wood (Archie Woods)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-3000

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1898

8. AGE: Years	Months	Days	If less than one day
47	1	2	..hr. ..min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Woods (D
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Broadway (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Robert L. Gouldy
(b) Address 804 N. Carrollton Ave.

JUN 1 1945 (Date rec'd by Registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29th, 1945 19.., at 7.1 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28-1945 to 5-29-45 19.., and that I last saw him alive on May 29 19 45

Immediate cause of death Respiratory Paralysis — Duration 8 hrs.
Due to Spinal Anaesthesia — 8 hrs.
Due to
Other Conditions Perforated Duodenal ulcer 5 days 3-4 days
advanced Paralytic Ileus
(Include pregnancy within 3 months of death)
Date of operation 5-29-45
Major findings of operation: Perforated Ulcer Ileus
of autopsy: Atelectasis, Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Cunningham M. D.
Address Balto City Hospitals Date signed 5-29-45

VS 150

Embalmed. Burial to be made, subject to Medical Examiner

B.C. # 24653
G29338

3-29591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G29338

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ld
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Pachwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shor

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 19 45

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Manuel Shor
13. Birthplace Balto

MOTHER
14. Maiden Name Selma Pell
15. Birthplace Balto

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Belair Rd & Parkside Lane

18 (a) Funeral director Jos Young Inc
(b) Address 1439 E. Balto St

19 (a) MAY 31 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 45 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 19 45 to May 30 19 45
and that I last saw h[illegible] alive on May 30 19 45.

Immediate cause of death Respiratory Failure — Duration
Due to Premature Birth
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Brown M.D.
Address Sinai Hosp Date signed 5/31/45

Robert T. Brown

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G29339 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Rukeland & Rayner 26

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 4362 Sheldon Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Caralyn Feete

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMA	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 27-1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace BALTO MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name E. MARSHALL. FEETE

13. Birthplace MARYLAND

MOTHER 14. Maiden Name CAROLINE HANCOCK.

15. Birthplace BALTO MD

16 (a) Informant E MARSHALL. FEETE

(b) Address 4362 SHELDON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-31-45 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN CEM.

Location EASTERN AVE ROAD

18 (a) Funeral director Bernard C Hartz

(b) Address 121

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945; at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945 to May 30 1945, and that I last saw h.e.r alive on May 30 1945.

Immediate cause of death Pneumonia

6 months Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 5/30/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

623840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 623840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Rebecca Myers

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Chester Myers

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 26 1894

8. AGE: Years 50 | Months 7 | Days 2 | If less than one day — hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business none home

FATHER 12. Name Henry Snowden

13. Birthplace unknown

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Sheba Garlington

(b) Address 920 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28 1945, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1944, to 5-4-1945, and that I last saw her alive on 5-27 1945

Immediate cause of death	Duration
Nephritis	unknown
Due to	
Due to	
Other Conditions. myocarditis	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark B. Saunders M. D.

Address 1029 N. Stricker St Date signed 5-30-45

VS 150

G29:341

472920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G29:341 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Amity St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Anna Eaton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-27-29

8. AGE: Years	Months	Days	If less than one day
15	11	1	..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Louis Eaton
13. Birthplace N.C.

MOTHER
14. Maiden Name Veralia Hicks
15. Birthplace N.C.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1 1945 (month) (day) (year)
(c) Cemetery or crematory Littleton.
Location North Carolina

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) ..... (b) .....
(Date rec'd by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 28 1945 at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945 to May 28 1945, and that I last saw her alive on May 28 1945

Immediate cause of death Miliary tuberculosis

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp Date signed 5/29/45 M.D.

G29342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29342 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 S. Chester street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 325 S. Chester street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Stefan Filipiak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Jozefa Filipiak (If alive, give age years)

7. Birth date of deceased (mo., day, yr.) Nov. 1888

8. AGE: Years	Months	Days	If less than one day
56	6		hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation plumber
11. Industry or business Adam Gmurek

FATHER
12. Name Jiarge Filipiak
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Mikolajczyk
15. Birthplace Poland

16 (a) Informant Mrs. Helen Jitkinski
(b) Address 325 S. Chester street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 1 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John F. Welsh
(b) Address 401 S. Chester street

19 (a) (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945 to May 28 1945, and that I last saw h alive on May 28 1945

Immediate cause of death Hypostatic Pneumonia — Duration 5/25/45

Due to Ch. Myocard. I.? — 1/1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wallace J. Rosner M. D.
Address 801 N. Kenwood Ave. signed 5/30/45

VS 150

G29343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29343 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Montgomery Co. Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Benjamin Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lewis T. Jones
(b) Address 3 Caretta M. Boston, Mass

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1937 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.
18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 1631 Druid Hill Ave

MAY 31 1937 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1937, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Pulaski M.D. Medical Examiner.
Date signed May 26 1937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~315~~ 629344 BALTIMORE CITY HEALTH DEPARTMENT 629344

CERTIFICATE OF DEATH 93C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 E Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 E Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie E Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George A Davis Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1872

8. AGE: Years	Months	Days	If less than one day
73	0	12	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Herman J Kimble
13. Birthplace Europe

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant George A Davis Sr.
(b) Address 1822 E Lafayette Ave

17 (a) Burial (b) Date thereof June 2, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral, Balto.
Location Baltimore, Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address St Paul & Preston St, Balto., Md

19 (a) MAY 31 1945 (b) Huntington Williams M.D. Registrar
(Date and day registered)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1945 to May 30 1945 and that I last saw h e r alive on May 29 1945

Immediate cause of death Myocarditis - — Duration 3 weeks

Due to Arteriosclerosis - — 4 mo.

Due to

Other Conditions Rheumatoid arthritis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 319 Nor 64 Ave Date signed 5-31-45

VS 150

G29345

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29345

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4135 Park Heights Ave St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Annie M Lightner

If U. S. Veteran specify WAR

(a) Residence: No. 4135 Park Heights Ave St., 15-13 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hamilton W. Lightner

6. DATE OF BIRTH (month, day, year) Jan. 4 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	4	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) York Co., Pa

FATHER

13. NAME John D. Rebert

14. BIRTHPLACE (city or town) (State or country) York Co., Pa.

MOTHER

15. MAIDEN NAME Melvina Myers

16. BIRTHPLACE (city or town) (State or country) York Co., Pa.

17. INFORMANT Hamilton W. Lightner

(Address) 4135 Park Heights Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Druid Ridge Date 5-31 1945

19. UNDERTAKER Loring Byers

(Address) 5005 Park Heights Ave

FILED MAY 31 1945 19 at. for Wm. [illegible] Registrar.

NOTE—WRITE PLAINLY, WITH ONE ENDING IN EACH SPACE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 5

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 28 1945

22. I HEREBY CERTIFY, That I attended deceased from May 28 1945 to May 28 1945

I last saw h[illegible] alive on May 28 1945 Death is said to have occurred on the date stated above, at 9.35 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	5 hrs
Arteriosclerosis	

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, how?

(Signed) John D Rebert M. D.

(Address) 4803 Park Heights Ave

Howard J. Mueller, M.D.

(Dr. Richardson) G29346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G29346 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Clipper Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Clipper Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Basil M. Smith.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower.

6 (b) Name of husband or wife Grace Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1859

8. AGE: Years	Months	Days	If less than one day
86	2	3	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Charles E. Smith
(b) Address 1504 Clipper Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden
18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Eastern Ave

19 (a) MAY 31 1945 (Date received by local registrar) Registrar Huntington Hillsman M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1945, at 9 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1943, to May 29 1945, and that I last saw h alive on May 29 1945

Immediate cause of death	Duration
Chronic Myocarditis	ndef
Due to	
Due to	
Other conditions Arteriosclerosis Chronic Nephritis	ndef

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L A Richardson M.D.
Address 112 W. 25th St Date signed May 31, 45

X

29347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 29347

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 [illegible] Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 N. Callington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES MILLARD METZ

3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-7600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Minna S. Metz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-22-09

8. AGE: Years	Months	Days	If less than one day
35	7	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Shoe Clerk
11. Industry or business

FATHER
12. Name Charles F. Metz
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Alt
15. Birthplace Md.

16 (a) Informant Sister
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville - Md.
18 (a) Funeral director John C. Melly Sons
(b) Address 2435 E. Oliver St.
19 (a) 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 9:35 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1945 to 5-29 1945 and that I last saw h[illegible] alive on 5-29 1945

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Congenital Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Glenn P. Sure
Address Union Memorial Hosp. Date signed M. D. 5/29/45

VS 150

G29348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1935

G29348 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Orchard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Orchard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	26	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Mason
15. Birthplace Va

16 (a) Informant Mrs. Lettie Williams
(b) Address 530 Orchard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) MAY 31 1945 (Date rec'd by reg'strar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Fractured hip - uncomplicated

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury July 1944 at ? M.
(b) Where did injury occur? 530 Orchard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slipped & fell

23. Signature Howard A. Kelly M.D. (Medical Examiner)
Date signed May 28, 1945

629349

629349

CWK-93899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 75- 2- 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Zoeberlein (or) John J. Zoeberlein

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4-1870

8. AGE: Years 75 | Months 2 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Paul Zoeberlein
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Frederick
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel & Sons
(b) Address Lombard & Ann Sts.

19 (a) MAY 31 1945 (Date received by registrar) (b) Huntington Wilkinson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945, to May 30 1945, and that I last saw him alive on May 30 1945.

Immediate cause of death: Cardiac failure — Duration

Due to

Due to

Other Conditions Carcinoma of kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M.D.
Address Baltimore City Hospitals Date signed 5-30-45

W. J. Mullis Board of Medical Examiner

G29350

AB-93641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G29350

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Granby St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Kaimina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: H

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8- 1901

8. AGE: Years 43 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Hawaii
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Antonio Kaimina (D)
13. Birthplace Hawaii

MOTHER
14. Maiden Name Mary ?
15. Birthplace Hawaii

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Mathias
Location Adamel St

18 (a) Funeral director Riegel & Ripple
(b) Address 312 S. Highland Ave

MAY 31 1945 (Date received by registrar) Huntington Willis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28- 1945, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1945, to 5-28 1945, and that I last saw h im alive on 5-28 1945.

Immediate cause of death Miliary tuberculosis

Due to

Due to Arteriosclerotic heart disease

Other Conditions Congested heart failure.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration
?
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Hultgen

Address Balto City Hosp Date signed 5-29-45

VS 150

G29:351

Lombardo

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1131a

Registered No. G29:351

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 N. Patterson Pk
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Patterson Pk
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katharine Kromadnika

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Kromadnik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1866

8. AGE: Years 78 | Months 7 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Bohemia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Urbek
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Bessie Portell
(b) Address 3325 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2. 1945. (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Balto Md

18 (a) Funeral director Frank Brachaton
(b) Address 900 E Chester st

19 (a) MAY 31 1945 (Date rec'd by registrar) (b) Filed Washington Hill, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 1245 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to May 29 1945 and that I last saw her alive on May 28 1945

	Duration
Immediate cause of death: Acute dilatation of Heart	3 days
Due to: Cardio-renal vascular disease	?
Due to:	
Other Conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Lucian W. Baker
Address 845 N. Patterson Pk. Ave. Date signed 5/29/45

VS 150.

629352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

629352 2270
Registered No. 61389 TC-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Memphis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 161½ N. Main Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Keasler, Harold Irvin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1893

8. AGE: Years	Months	Days	If less than one day
51	8	10	hr. min.

9. Birthplace Ladonia, Texas
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafaring

FATHER
12. Name John R. Keasler
13. Birthplace Rome, Georgia

MOTHER
14. Maiden Name Reala Irving
15. Birthplace Dainield, Texas

16 (a) Informant U.S Marine Hospital Records
(b) Address Wyman Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory
Location Shreveport La

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd.

19 (a) MAY 31 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 7.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945, to May 30 1945, and that I last saw him alive on May 30 1945

	Duration
Immediate cause of death Pyloric obstruction	2 mos.
Due to Carcinoma of tongue	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/18/45
Major findings of operation: Jejunostomy
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address U.S. Marine Hospital Date signed 6/31/45
Baltimore 11, Maryland

629353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

629353 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 679 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4+

(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 679 Vine St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Tripp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Joseph Tripp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Foster
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Pearl Cosby
(b) Address 427 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Schroeder St

19 (a) MAY 31 1945 (Date rec'd by local reg.) (b) Huntington Titus (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1945, at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 29 19..., and that I last saw her alive on May 25 1945.

Immediate cause of death: Cardio Vascular Renal Disease — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. William Frey M. D.

Address 927 Pa. Ave Date signed 5/31/45

X

629354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 629354

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 N. Bruce
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) Nov
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Bruce (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Bankins

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mamie Bankins
6 (c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Aug 14 1876
8. AGE: Years 68 | Months 9 | Days 13 | If less than one day: hr. min.
9. Birthplace: St Mary Leo Md (Town, county, and state)
10. Usual Occupation: Driver
11. Industry or business:

FATHER
12. Name: Chas Bankins
13. Birthplace: St Mary Leo

MOTHER
14. Maiden Name: Lucy Hall
15. Birthplace: St Mary Leo

16 (a) Informant: Mamie Blankins
(b) Address: 424 N. Bruce

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1945 (month) (day) (year)
(c) Cemetery or crematory: St. Peter's Cemetery
Location:

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 323 N. Schroeder St

19 (a) MAY 31 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to May 27 1945.
And that I last saw him alive on May 27 45

Immediate cause of death: Chronic Myocarditis — Duration: 1 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(d) Means of injury:

23. Signature: F B Lusk M. D.
Address: 1006 Park Ave Date signed May 28 1945

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G29355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Waynesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 S. Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth Alden Stone Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	w	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/27/45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Kenneth Alden Stone

FATHER 13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden Name Dorothy Ethel Nicodemus

MOTHER 15. Birthplace Green Castle Pa

16 (a) Informant Mrs. Kenneth A. Stone

(b) Address 34 S. Church St. Waynesboro Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)

(c) Cemetery or crematory Greenhill Cem

Location Waynesboro, Pa.

18 (a) Funeral director K.B. Stone, (Father)

(b) Address

19 JUN 1 - 1945 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945, to May 31 1945, and that I last saw him alive on May 31 1945.

Immediate cause of death: Premature - 5 months

Due to: Md & Tissues

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John McF Bongland MD M. D.

Address 1015 E. Baltimore St. Date signed 5/31/45

G29356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G29356 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2
(c) Hospital or institution: Hospital for Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Waynesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 S. Church Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sally Ann Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/27/43

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Kenneth Alden Stone
13. Birthplace Hagerstown, Md

MOTHER
14. Maiden Name Dorothy Ethel Nicodemus
15. Birthplace Green Castle Pa

16 (a) Informant Mrs. Kenneth A. Stone
(b) Address 34 S. Church St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/43 (month) (day) (year)
(c) Cemetery or crematory Greenhill Cem
Location Waynesboro, Pa

18 (a) Funeral director A. Stone, (Father)
(b) Address

19 (a) JUN 1 - 1945 Washington, Williamson, Registrar (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945; at 3 p M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945 to May 31 1945, and that I last saw h[illegible] alive on May 31 1945.

Immediate cause of death — Bronchopneumonia — 5 weeks
Due to — Burns, Thermal
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John McF Berglund M.D.
Address 1010 St Paul Street Date signed 6/3/45

X

G29357

AB-93728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G29357 (new)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brines La Prade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29- 1897 1900

8. AGE: Years	Months	Days	If less than one day
58 45	1	29	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James La Prade (D)
13. Birthplace ?

MOTHER
14. Maiden Name Ella Johnson (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6-5-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location West Baltimore Gray & G. Gibson

18 (a) Funeral director
(b) Address 1785 Druid Hill Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28- 1945, at 4.40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21- 1945, to 5-28 1945, and that I last saw h im alive on 5-28- 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis Bilateral	1 year
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dellon, M. D.
Address Balto City Hosp Date signed 5/29/45

VS 150

629358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

629358 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day Mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Lewis

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/45

8. AGE: Years | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wm Lewis
13. Birthplace Md

MOTHER
14. Maiden Name Grace Evans
15. Birthplace Md.

16 (a) Informant Wm Lewis
(b) Address 1105 Edmondson Ave

17 (a) Mt Auburn (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)
(c) Cemetery or crematory Burial
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Preastman St

19 (a) JUN 1 - 1945 (Date rec'd by local reg.) (b) Huntington White Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945, at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed May 30, 1945.

6293:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64 Registered No. 6293:59

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 N. Mount St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No) (If yes) name country.....

3 (a) FULL NAME James Anton Irvin Mitchell

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/4/43

8. AGE: Years 2 | Months - | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Anton Irvine
13. Birthplace Va.

MOTHER
14. Maiden Name Magnolia Mitchell
15. Birthplace N.C.

16 (a) Informant Magnolia Mitchell
(b) Address 1106 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 6/4/43

(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Freemason St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymico - lymphaticus

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at.....M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Howard J. Waldein M.D. Medical Examiner.

Date signed 5-31-46

VS 151

G29360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

G29360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Hamilton ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Hamilton ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Austin Jenkins Keen (Keen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Annie Kennedy
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 18 1866

8. AGE: Years	Months	Days	If less than one day
78	11	11	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation retired farmer
11. Industry or business

FATHER
12. Name Austin Keen
13. Birthplace Md.

MOTHER
14. Maiden Name Margarit Jenkins
15. Birthplace England

16 (a) Informant Mrs. Geo. Keen
(b) Address Halethorpe Md.

17 (a) Burial (b) Date thereof June 1 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7744 Eastern ave.

18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw Place

19 (a) JUN 2 1945 (b) Huntington Registrar MK

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29- 1945; at 10-15 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions Adeno-carcinoma of prostate

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 5-29-45

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G29361 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution SB GH. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Wk 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis N. Butler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Alma Butler
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 10/1899

8. AGE: Years 45 | Months 7 | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation junk dealer
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Laura Williams
15. Birthplace S. C.

16 (a) Informant Alma Butler
(b) Address 114 N Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaac L. Brown's Son
(b) Address 109 W Monument St

19 (a) JUN 1 - 1945 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28-1945 at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12-1945 to 5-28-1945, and that I last saw h. l. alive on 5-28-1945.

Immediate cause of death [redacted] Tbc. peritonitis — Duration 4wks

Due to pulmonary tbc.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Tbc. peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kohlick M. D.
Address 1213 Light St. Date signed 5-29-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G29362 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 866 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 866 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Philemon Miles.
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Harriet E. Miles.
6 (c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) June 16, 1875
8. AGE: Years 69 Months 11 Days 15 If less than one day hr. min.
9. Birthplace Montgomery Co. Md.
(Town, county, and state)
10. Usual Occupation Mfg. of Salads.
11. Industry or business Self.

FATHER
12. Name Wesley Miles
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Jane Phillips
15. Birthplace Missouri.

16 (a) Informant Harriet E. Miles.
(b) Address 866 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/45 (month) (day) (year)
(c) Cemetery or crematory Howard Chapel
Location Howard Co. - Md.

18 (a) Funeral director Howard M. Blight, Jr.
(b) Address 4914 Belair Road.

19 (a) (Date received by registrar) JUN 1 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 1 1945, at 1 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 - 1 1945 to 6 - 1 1945 and that I last saw h[im] alive on 5 - 31 - 1945

Immediate cause of death Carcinoma Lung — Duration ?
Due to —
Due to —
Other Conditions Carcinoma Stomach — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.
Address 5 W. Fulton Ave Date signed 6-1-45

AdCo. 5-31 2508

HEALTH DEPARTMENT—CITY OF BALTIMORE

629:363 13/a 629:363

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Asquith St St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Rachel Ross

(a) Residence: No. 112 Asquith St., 5-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 1856

7. AGE 89 Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housewife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 65 yrs

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME John Hazelton

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Marjorie Ross (Niece)
(Address) 1453 N. Carey St

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Auburn Date June 2 1945

19. UNDERTAKER Va Brooks
(Address) 1463 N. Carey St

20. FILED JUN 1 - 1945 Huntington Williams M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 30 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 1945 to May 30 1945

Last saw h. alive on May 29 1945 death is said to have occurred on the date stated above, at 10:10 P.M.

The **principal cause of death** and related causes of importance were as follows:

Date of onset

Cerebrovascular Accident
Complications

Other **contributory causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (**violence**) fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in **industry**, in **home**, or in **public place**.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) J. Hazelton M. D.
(Address) 632 Dunbar St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G29564 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1897

8. AGE: Years 47 | Months 8 | Days | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Payne
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Davis
(b) Address 807 Old Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) JUN 1 1945 (Date filed by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945 at 12 A.M. 20

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Stab wounds of arm and hand, left

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/27/45 at 11:50 P. M.
(b) Where did injury occur? 615 Cumberland St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? ---
(d) Means of injury Slashed w/razor

23. Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed May 28 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1102

G29365 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Green Willow St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula May Haynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1932

8. AGE: Years	Months	Days	If less than one day
13	3	9	hr. min.

9. Birthplace Riceville, Ga.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Remus Haynes
13. Birthplace Georgia

MOTHER
14. Maiden Name Lottie Haynes
15. Birthplace Georgia

16 (a) Informant Mrs. Lottie Haynes
(b) Address 607 Greenwillow St.

17 (a) Burial (b) Date thereof June 2, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ant. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Lowe
(b) Address 802-04 Madison Ave.

19 (a) (b)
(Date rec'd by registrar) Huntington Woolford, M.D. Registrar

JUN 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 2¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944, to May 29 1944, and that I last saw h alive on May 29 1944.

Immediate cause of death Medullary shock.

Due to Adenocarcinoma of Lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation May 22 1944

Major findings of operation: Emphysema

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S. Drake M. D.
Address Univ. Hosp. Date signed 5-30-44

X

6-29-366 HEALTH DEPARTMENT—CITY OF BALTIMORE 6-29-366

CERTIFICATE OF DEATH 1312

1. PLACE OF DEATH Home for Aged. Registered No.

CITY OF BALTIMORE: (No. 2211 W. Rogers Ave. Balto. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 83 yrs. 10 mos. 15 ds. How long in U. S. If of Foreign Birth? yrs. mos. ds.

2. FULL NAME Julia Abbott

(a) Residence: No. Home for Aged. 2211 W. Rogers Ave. Balto. 9.
(Usual place of abode) St., Ward (If non-resident give city or town and State)

27-15

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female | 4. Color or Race: White | 5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Abbott

6. DATE OF BIRTH (month, day, year): Aug 16 1861

7. AGE: Years 83 | Months 9 10 | Days 15 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: —

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Baltimore

FATHER

13. NAME: Thomas Goldman

14. BIRTHPLACE (city or town) (State or country): Baltimore

MOTHER

15. MAIDEN NAME: Emma Betts

16. BIRTHPLACE (city or town) (State or country): Baltimore

17. INFORMANT: A. Virginia Savage
(Address): 2211 W. Rogers Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place: London Park Date: 6-3 1945

19. UNDERTAKER: Tillman & Ford
(Address): 5904 York Road

20. FILED JUN 1 - 1945 19 Huntington Willis Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): May 31 1945

22. I HEREBY CERTIFY, That I attended deceased from June 1942 to May 28 1945

I last saw h.. alive on May 28 1945 Death is said to have occurred on the date stated above, at 4 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	?
Cerebral Thrombosis	
Other contributory causes of importance: Chr. cardio-vascular renal disease	?

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? Phys. Exam. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.

Charles L. Wagner M.D.

(Address) 421 Med. Arts Bldg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

G29367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G29367 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madison
(c) Hospital or institution: Maryland General Hospital 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 N Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mrs. Katie Bastigkeit

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Charles E.
6 (c) If alive, give age ~~90~~ years

7. Birth date of deceased (mo., day, yr.) Dec. 26. 1871

8. AGE: Years	Months	Days	If less than one day
73	5	4	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Reinhardt Brandt
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Leonbach
15. Birthplace Germany

16 (a) Informant Elizabeth Fritzsche
(b) Address 1522 n Bethel St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location O'Donnell St

18 (a) Funeral director Blanche F. Hoffman
(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 9.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1945, to 5/30 1945, and that I last saw her alive on 5/30 1945.

Immediate cause of death	Duration
Terminal Pneumonia	6 hours
Cardio-vascular collapse	
Due to Carcinoma of bowel	
Due to	
Other Conditions Generalized debilitation	

(Include pregnancy within 3 months of death)
Date of operation 5/25/45
Major findings of operation: Ca of large bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Traynor M. D.
Address Md. Gen. Hosp. Date signed 5/30/45

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29368 CERTIFICATE OF DEATH ✓ 186a G29368

1. PLACE OF DEATH Home for Aged Registered No.

CITY OF BALTIMORE: (No. 2211 W. Rogers Ave. St., Balto 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 84 yrs. 2 mos. 30 dys. How long in U. S. if of foreign birth? 27-9 yrs. mos. dys.

2. FULL NAME Elizabeth Heath

(a) Residence: No. Home for Aged St., 2211 W. Rogers Ave. Balto 9 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. Sex: Female
4. Color or Race: White
5. Single, Married, Widowed, or Divorced (write the word): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Wm. Heath
6. DATE OF BIRTH (month, day, year): Mar. 1. 1861

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	2	30	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: None
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: None
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Balto. Md

FATHER
13. NAME: Laurence Miller
14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER
15. MAIDEN NAME: Catherine Cashmeier
16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT: A. Virginia Savage.
(Address) 2211 W. Rogers Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place: Laurel Memorial Date: 6-4 19 45

19. UNDERTAKER: Wilhom Corbin
(Address) 1217 W. Fayette St.

20. FILED JUN 1 - 1945 19 Katie Lee Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): May 31, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 15, 1945 to May 31, 1945

I last saw her alive on May 28, 1945 Death is said to have occurred on the date stated above, at 7:20 p.m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Arteriosclerosis	2
Myocarditis - chronic	
Other contributory causes of importance: Fractured left radius	6-15-45

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? X-ray Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 5-15 1945
Where did injury occur? Fell on steps
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place Home for Aged
Manner of injury Fall. Fract. left radius
Nature of injury " "

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

Charles L. Wagner M. D.
(Address) 421 Med Arts Bldg

approved by Howard J. Masseio, M.D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G29369 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green & Redwood Sts

(c) Hospital or institution: University Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 2 (If outside city or town limits, write RURAL and give town)

(d) Street No. 46 1/2 Hampnett Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Clara Maurer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife late Anthony Maurer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	26	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Home Work

11. Industry or business

FATHER 12. Name Henry Quaster QUASTER

13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Janetzke

15. Birthplace Germany

16 (a) Informant Mrs Joseph A. Kent

(b) Address 46 Hampnett Ave

17 (a) Burial (b) Date thereof June 7/45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Bucks, Md

18 (a) Funeral director Henry H. Leitzke

(b) Address 401 Edmondson Ave

19 (a) (b) (Date received by Registrar) JUN 1 1945 Registered M.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30/45 1945 at 8.25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1945, to 5/30 1945, and that I last saw her alive on 5/29 1945

Immediate cause of death	Respiratory failure	Duration
Due to	Lobar pneumonia	10 days
Due to		
Other Conditions	Bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles D. Chaput M. D.

Address University Hospital Date signed 5/30/45

G29370 G29370

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Cookie St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Cookie St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Herleth (Wiekmann)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Rapiolus Herleth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1871

8. AGE: Years 74 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Charles Herleth
(b) Address 743 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dill
(b) Address 1571 E. Fort Ave.

JUN 1 - 1945 Huntington Williams M.D. (Date rec'd by registrar) Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to May 30 1945 and that I last saw her alive on May 30 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration: Last Hour

Due to: Myocarditis

Due to: Cardiac decompensation producing Pneumonia-Sarcoma-Cachexia

Other Conditions: Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Norris M.D.
Address 107 East West Street
May 31, 1945

G29371 G29371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S. Greene St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK HENRY

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. 215-24-7741

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Francis Henry.

6 (c) If alive, give age V years

7. Birth date of deceased (mo., day, yr.) — 1912

8. AGE: Years 33 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lynchburg, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Zack Henry
13. Birthplace South Carolina

MOTHER
14. Maiden Name Rosa Durham
15. Birthplace South Carolina

16 (a) Informant Ada Durham
(b) Address 609 S. Green St.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 6 / 1 / 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemtery
Location Balto., Md.

18 (a) Funeral director Walter B. Spriggs
(b) Address 139 W. Hamburg St.

19 (a) JUN 1 - 1945 (Date rec'd by registrar) (b) Permit issued by Williams M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29/45 19..... at 5:37 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic Aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 6/8/45

629372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

629372 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 2 9da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Hyndman Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annabelle Thornhill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days 31 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Housewife Unk
13. Birthplace Va

MOTHER: 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Calvin Thornhill
(b) Address 1803 Eye Fullough St

17 (a) (Burial, cremation, or removal) (b) Date thereof 6 (month) (day) (year)
(c) Cemetery or crematory Highland
Location Uppon Rd & Gibson
18 (a) Funeral director Chas. R. Gibson
(b) Address 1738 E. Oliver St Balto

19 JUN 1 - 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1945, at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1945 to 5/31 1945, and that I last saw her alive on 5/31 1945

Immediate cause of death Uremia — Duration

Due to Uncontrolled Diabetes

Due to Diabetic Gangrene of Rt Foot

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/29/45

Major findings of operation: Mid-Tibial Amputation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. K. Goodbody Jr. M. D.
Address Yours Hosp Date signed 5/31/45

629373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

629373 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Old Spring Ave & Belvedere

(c) Hospital or institution: Hebrew Aged Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Old Spring & Belvedere Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Selmum Wittenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widow

6 (b) Name of husband or wife Rena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business —

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Sam Wittenberg

(b) Address 5104 - 2nd St. N.W. Wash., D.C.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-1-45 (month) (day) (year)

(c) Cemetery or crematory Levindale

Location

18 (a) Funeral director Jack Sairs Inc

(b) Address 1439 E. Balto. St

19 (a) (Date) Filed by registrar 6-1-1945 Registrar

Huntington Hospital

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1-45 19 , at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1945, to 6-1 1945, and that I last saw h~~im~~er alive on 6-1 1945.

Immediate cause of death	Duration
Chr. cerebral vascular disease	
Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Helmund Levin

Address Levindale Date signed 6/1/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629574 629574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Springdale Springhill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Springdale ave
(If outside city or town limits, write R.F.D., and give town)
(d) Street No. 4210 Springhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Teichman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-01-9346

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Mutual Seller
11. Industry or busines Rail Trade

FATHER
12. Name Samuel
13. Birthplace Austria

MOTHER
14. Maiden Name Amplei
15. Birthplace Austria

16 (a) Informant Anna Teichman
(b) Address 4210 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Balto St

19 (a) JUN 1 - 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31-45 19 , at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 5/30 1945, and that I last saw h alive on 5/30 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 5/31/45

VS 150

G29375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G29375

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 442 E 28th St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 442 E 28th St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Gifford Borrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-7402

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nellie Kilduff

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1889

8. AGE: Years	Months	Days	If less than one day
55	8	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Claim Investigator

11. Industry or business B & O RR

FATHER

12. Name Pablo M Borrell

13. Birthplace Cuba

MOTHER

14. Maiden Name Jane Gifford

15. Birthplace Baltimore

16 (a) Informant Mrs. Nellie Borrell

(b) Address 442 E 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

19 (a) JUN 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30-1945, at 11 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27-1945 to 5-30-1945; and that I last saw him alive on 5-29-1945.

Immediate cause of death Apoplexy — Duration 3 days

Due to Arteriosclerosis Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm. B. Seybert M. D.

Address 1907 Harford Rd Date signed 5-31-45

X

G29376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G29376 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma F. Crowley

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William J. Crowley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1878

8. AGE: Years 67 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Henry Feldman
13. Birthplace Germany
14. Maiden Name Elizabeth Schafer
15. Birthplace Va.

16 (a) Informant Mrs. John R. Hoffman
(b) Address 2931 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (d) JUN 1 - 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31/45 19.... at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1945, to 5/31 19 45
and that I last saw h.... alive on 5/31 19 45

Immediate cause of death
Uremia
Due to Benign Nephro-sclerosis
Due to
Other Conditions Hypertrophy of Prost
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Same as above
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St. Agnes Hosp. Date signed 5/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29377 G29377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Light St.
(c) Hospital or institution: South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Guilford Ave (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET MINTER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 26, 1924

8. AGE: Years	Months	Days	If less than one day
20	11	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Befrawler
11. Industry or business Sun Papers

FATHER
12. Name Hugh Minter
13. Birthplace S. C. (Columbia)

MOTHER
14. Maiden Name Margaret Ely
15. Birthplace Balto.

16 (a) Informant Fdm Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 1 - 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1945 to 5/31 1945 and that I last saw h[illegible] alive on 11:20 AM. 1945

Immediate cause of death: Typhoid Fever — Duration: 31 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Madison Blayton III M. D.
Address South Balto Gen Hosp Date signed 6/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29578 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Vista Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Hudson

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Clara Bowen Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1878

8. AGE: Years	Months	Days	If less than one day
67	4	11	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Pharmacist

11. Industry or business: Morgan & Millard

FATHER
12. Name: George Hudson
13. Birthplace

MOTHER
14. Maiden Name: Lydia Fox
15. Birthplace: Va.

16 (a) Informant: Mrs. Robert Zimmerman
(b) Address: 4405 Vesta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUN 1945 (Date rec'd by registrar) (b) Huntington Avenue M.F. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Inspection & Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D. Medical Examiner.
Date signed 5-31-45

629.879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1155

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Springlake Gray
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5202 Springlake Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME William Dungan Lamdin
3 (b) If veteran, name war: World I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife: Eleanor Clarke Lamdin
6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1891

8. AGE: Years	Months	Days	If less than one day
53	5	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Architect
11. Industry or business Palmer & Lamdin

FATHER
12. Name Abel Dungan Lamdin
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Elizabeth McFarland
15. Birthplace Maryland (Elkton)

16 (a) Informant Mrs. William D. Lamdin
(b) Address 5202 Springlake Way.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 6-1-1945 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31 1945 at 12:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 1945, to 5-31 1945, and that I last saw h/M alive on 5-31 1945.

Immediate cause of death Cardiorespiratory failure — Duration
Due to Med. cerebral hemorrhage. — Duration
Due to — Duration
Other Conditions Infected ft. submaxillary gland. — Duration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn C. Bran
Address Union Memorial Hosp. Date signed 5/31/45 D.

X

G29330 G29330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 434a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2424 Edmondson Ave.
(c) Hospital or institution: 165
(d) Length of stay in hospital or inst. (yrs., mos., or days) a
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH WEAVER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	-Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1868

8. AGE: Years	Months	Days	If less than one day
77	0	22	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. H. Weaver
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Hannah R. Wallace
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles Wallace
(b) Address Union Trust Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 1 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24-45 19 to 5-30 19 45 and that I last saw h er alive on 5-28-45.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days

Due to Hypertension Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Bemiller M. D.
Address 703 Edmondson Ave Date signed 6-1-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G29381

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 915 North Hill Rd.

(c) Hospital or institution: 91

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 915 North Hill Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME CHARLES A. DONNELLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary A. Donnelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	27	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Pressman

11. Industry or business

FATHER

12. Name William Charles Donnelly

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Jennie Geddes

15. Birthplace Balto., Md.

16 (a) Informant Mr. H. G. Donnelly

(b) Address 915 North Hill Rd.

17 (a) Burial (b) Date thereof 6/2/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUN 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1945 to 5/30 1945, and that I last saw him alive on 5/29 1945.

	Duration
Immediate cause of death myocardial insufficiency	1 day
Due to conditis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. C. Whitelaw

Address 4474 Kenwood Ave. Date signed 6/1/45 M. D.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29382

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2812 Delmont Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME LOUIS HARTMAN, Sr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Margaret W. Hartman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1863

8. AGE: Years 82 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Wood Finisher

11. Industry or business

FATHER

12. Name Frank Hartman

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Lutz

15. Birthplace Germany

16 (a) Informant Mrs. Catherine Hammel

(b) Address 2812 Delmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) 1945 (Filed by registrar) (b) Huntington Hillen (Registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH May 30, 1945, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945 to May 30 1945, and that I last saw h alive on May 29 1945.

Immediate cause of death: cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. H. Cutterman, M. D.

Address 2324 Reisterstown Rd. Date signed 6/4/45

VS 150

629383 West 629383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 911 McHenry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 McHenry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Edna West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm. J. West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1900

8. AGE: Years 44 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Trunk.
13. Birthplace Md.

MOTHER
14. Maiden Name Steele
15. Birthplace Md.

16 (a) Informant Family
(b) Address 911 McHenry

17 (a) B- (Burial, cremation or removal) (b) Date thereof 6-27-45 (month) (day) (year)
(c) Cemetery or crematory Bethany Memory Gardens
Location Belair Rd & Moravia Rd.

18 (a) Funeral director J. F. McCarthy
(b) Address 802 E. Fort Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 1945, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Pulmiter M.D.
Medical Examiner.
Date signed 6-28-45

G29384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G29384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Carroll
(c) City or town Smallwood (If outside city or town limits, write RURAL and give town)
(d) Street No. Near Westminster (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Poole

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife None.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-45 aged 28

8. AGE: Years	Months	Days	If less than one day
16	11	5	hr. min.

9. Birthplace Smallwood, Carroll Co, Md (Town, county, and state)
10. Usual Occupation Congoleum Nairn Wor Plant
11. Industry or business Finksburg Md

FATHER
12. Name Edward T. Poole
13. Birthplace Gist, Carrol Co, Md

MOTHER
14. Maiden Name Catherine E. Saylor
15. Birthplace Smallwood, Md.

16 (a) Informant Edward T. Poole
(b) Address Westminster, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-45 (month) (day) (year)
(c) Cemetery or crematory Deer Park
Location Smallwood, Md.

18 (a) Funeral director Francis Reese
(b) Address Westminster, Md.

19 (a) JUN 1 1945 (Date rec'd by registrar) (b) Huntington Hiltz Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1- 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd & 3rd degree burns.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Carroll Co.
(a) Date of injury 5/31/45 at 11:30 P. M.
(b) Where did injury occur? Congoleum C. - Finksburg
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Fell in tub of boiling water.

23. Signature Howard J. Mudd M.D.
Medical Examiner.
Date signed 6-1-45

X

1 T G29385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

G29385 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3/1880

8. AGE: Years 65 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Prince Edward Co Va.
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
12. Name Abram Morgan
13. Birthplace Va

MOTHER
14. Maiden Name Priscilla Redd
15. Birthplace Va.

16 (a) Informant Jane Anderson
(b) Address 1706 Ashland Ave

17 (a) Removal (b) Date thereof June 1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Farmville Va.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Caroline St.

19 1945 Huntington Williams, Registrar
(Date rec'd by registrar)

UNDERTAKER

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1945 to 6/31 1945 and that I last saw h alive on 6/31 1945.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Myocarditis

Due to Nephritis

Other Conditions Hypertension Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Lafark M. D.
Address 822 N. Broadway Date signed 6/1/45

X

629386 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95 B 629386 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1320 Orleans St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Powell

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife William Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1921

8. AGE: Years	Months	Days	If less than one day
23	9	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business At home

FATHER
12. Name Willie Cole
13. Birthplace Md.

MOTHER
14. Maiden Name Pansy Wilburn
15. Birthplace Md.

16 (a) Informant Pansy Cornish
(b) Address 1320 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Druid Ley Ave.

19 (a) 1945 (Date received by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/45 19 , at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1945, to 5/28 1945, and that I last saw her alive on 5/27 1945.

Immediate cause of death Cardiac failure

Due to R.H.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Hoffberg M.D.
Address 618 N. Monroe St. Date signed 5/31/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

(G29387) Register No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 N. Chapel St DOA
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jemiah Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1903

8. AGE: Years 41 | Months 7 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace St. Marys Co., Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Parker Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Francis Burden
15. Birthplace Md.

16 (a) Informant George Dorsey
(b) Address 29 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley Ave

19 (a) JUN 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Cervix Uteri

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubinski M.D.
Medical Examiner.
Date signed 5/29/45

G29388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29388 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 Dundalk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Dundalk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Assunta Lazzeri

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife late Giuseppe Lazzeri
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1872

8. AGE: Years	Months	Days	If less than one day
73	1	8	hr. min.

9. Birthplace Aversa Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Olindo Sisi
13. Birthplace Italy

MOTHER
14. Maiden Name Filomena ?
15. Birthplace Italy

16 (a) Informant Gino Lazzeri (Son)
(b) Address 1419 Dundalk Ave

17 (a) Burial (b) Date thereof June 2 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (a) (b)
(Date rec'd by registrar) Registrar

JUN 1 - 1945

Purington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945 at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to May 31 1945 and that I last saw her alive on May 29 1945

Immediate cause of death Myocardial infarct

Duration 18 mos

Due to Arteriosclerosis

Duration 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Andrews M.D.
Address 2 Kenlop Rd Dundalk Md
Date signed 6/1/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29389
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4910 Crowson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Crowson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Pennington Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Davis

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 4th 1841

8. AGE: Years 23 | Months 10 | Days 20 26 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Levi Pennington
13. Birthplace Md

MOTHER
14. Maiden Name Rachael Sutton
15. Birthplace Md

16 (a) Informant Miss Amanda Pennington
(b) Address 4910 Crowson Ave

17 (a) Burial (b) Date thereof June 2
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Cety

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Orleans St

JUN 1 - 1945
(a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945, to May 30 1945, and that I last saw h.. alive on May 30 1945.

Immediate cause of death Coronary Thrombosis — Duration 4 days.

Due to —

Due to —

Other Condition Diabetes Mellitus — 9 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Allen Deckert M.D.
Address 1127 St Paul St Date signed 5/31/45

94a

G29390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111 C

Registered No. G29390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 W. Ostend Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 W. Ostend Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEWART W. CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN - 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945, at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Craton M.D.
Medical Examiner.
Date signed May 23 1945

537

G29391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G29391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED: Found
(a) State Md. (b) County 500 Blk Carrollton
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL JUN 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) JUN - 1 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1945, at 6:50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stroke -
Pneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed May 16, 1945.

2738

X

G29:392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 47c

G29:392

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town Appalachia. (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Samuel E. W Whittaker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Cleo M Whittaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-4-1884

8. AGE: Years	Months	Days	If less than one day
60	—	28	hr. min.

9. Birthplace Va. Tenn. (Town, county, and state)
10. Usual Occupation Retired Engineer
11. Industry or business Southern R.R.

FATHER
12. Name James W Whittaker
13. Birthplace Va Tenn

MOTHER
14. Maiden Name Emaline Conbby
15. Birthplace Tenn

16 (a) Informant Mrs Cleo. Whittaker
(b) Address JOHNS HOPKINS HOSPITAL Apalachia Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Booher Cem.
Location Oak Grove Va

18 (a) Funeral director E. Wilfis Lamoreaux
(b) Address 4610 Liberty Hgts Ave

19 (a) Waiting for Williams M.D. (Date rec'd by registrar) Registrar

JUN 1 - 1945

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1-1945, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1945 to 6-1 1945.
and that I last saw h.[illegible] alive on 6-1 1945.

Immediate cause of death	Duration
Lung abscess	
Due to Bronchogenic carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Joseph D.B. King M. D.
Address Johns Hopkins Hosp. Date signed 6-1

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G29393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Hynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Katie W. Hynes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20th 1890

8. AGE: Years 54 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Manager & Estimator

11. Industry or ~~business~~: McDade Transfer Co.

FATHER
12. Name Robert P. Hynes
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ella Herbert
15. Birthplace Havre de Grace Md.

16 (a) Informant Katie Hynes
(b) Address 3900 N Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 [illegible] Date rec'd by ~~registrar~~ Mailing for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 at 1 20 P.M. 35

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound Comminuted Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/1

(a) Date of injury 5/30/45 at 2:20 P.M. (Eng Highway)
(b) Where did injury occur? Patapsco Forge Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Blank fell on head

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed May 31 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2936 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2936 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA A. BADENHOOP

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Herman J. Badenhoop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Rieberbach
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Greiner
15. Birthplace Germany

16 (a) Informant Miss Hermine Badenhoop
(b) Address 2936 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6.2.45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945 at 8.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1945 to 5/31 1945 and that I last saw h[er] alive on 5/15 1945.

	Duration
Immediate cause of death Coronary occlusion	1 hr. ?
Due to Angina pectoris	2 yrs.
Due to Hypertension	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter M.D.
Address 3408 Windsor Ave. Date signed 6/1/45

G29395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓ Registered No. G29395

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Yosemite Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Yosemite Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Washington Henthorn

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 705-09-1510

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chief Water Inspector
11. Industry or business City of Baltimore

FATHER
12. Name George W. Henthorn
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Adeline Bullock
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Addie Henthorn
(b) Address 3711 Yosemite Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) JUN 2 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30/ 19 45, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30-1945 to 5-30-1945 and that I last saw h[illegible] alive on — 19 .

Immediate cause of death Coronary occlusion Interval between onset and death
Heart failure

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Poullon
Address 3904 Gawen Blvd Date signed 6/1/45 M. D.

Approved: John R. Davis by Howard J. Meeder, M.D. per E.R.

G29396 LINWOOD CARTER ✓ G29396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 S. Bielle Ln
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 S. Bielle Ln (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linwood Carter

3 (b) If veteran, name war War 1 —
3 (c) Social Security Account No. 217-07-0986

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband Leanie Barton
6 (c) If alive, give age 43 years

7. Birth date of deceased June 4 1901 —

8. AGE: Years 43 Months 11 Days 27 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Longshoreman
11. Industry or business Ship Scaling & Painting

FATHER
12. Name Unknown
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Anne Faith
(b) Address 729 S. Bielle Ln

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cemetery
Location

18 (a) Funeral director Charles H. Alexander
Address 1945 McCulloh Street
(Date rec'd by registrar) JUN 2 (Huntington Williams, M.D.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1/45 19 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/45 19 to 6/1/45 19
and that I last saw h— alive on 6/1/45 19
Immediate cause of death Cerebral Hemorrhage Duration Hrs.
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Lee Ellis M. D.
Address 729 S. Bielle Ln Date signed 6/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29397 ✓ G29397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temple Garden Aprt.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-1
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Aprt. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Germany.

3 (a) FULL NAME Emma Goldsmith,

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18th. 1863

8. AGE: Years 81 | Months 8 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Gearmany, (Town, county, and state)
10. Usual Occupation Saleslady.
11. Industry or business

FATHER
12. Name Edward Goldsmith.
13. Birthplace Geramny,

MOTHER
14. Maiden Name Caroline Hutzler.
15. Birthplace Geramny

16 (a) Informant Wm. Goldsmith.
(b) Address Temple Garden Aprt. 505

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 3rd, (month) (day) (year),
(c) Cemetery or crematory Har Sinai,
Location Balto

18 (a) Funeral director Baird Londheim & Son
(b) Address 19 N Eutaw St

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUN 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 89 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to June 1 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
General carcinomatosis	1 year
Due to Secondary to	
Due to Carcinoma of breast removed 5 years ago	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1940
Major findings of operation: Carcinoma of breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frederick Lentz M.D.
Address Temple Garden Apt. Date signed 6/1-45

X

629398 ✓ 629398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1332

Registered No. (nee)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. ...correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lake Drive Apt
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Drive Apts
(If rural give location)
(e) Citizen of foreign country? Germany (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Lee Gunst

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hedwig Gunst

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1876

8. AGE: Years 68 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Germany Richmond, VA.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Gunst
13. Birthplace Germany

MOTHER
14. Maiden Name Hofman
15. Birthplace

16 (a) Informant Mrs. Gunst
(b) Address Lake Drive Apts

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/3/45 (month) (day) (year)

(c) Cemetery or crematory Bethabah
Location Baltimore Md

18 (a) Funeral director David Londeree
(b) Address 1602 Eutaw Pl

19 (a) (Date rec'd by registrar) (b) Huntingtor Williams, M.D. Registrar

VS 150 JUN 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1945, to 6/1 1945, and that I last saw h. alive on 6/1 1945

Immediate cause of death	Duration
Pulmonary Edema	
Due to Myocardial Degeneration	
Due to Coronary Art. Disease	
Other Conditions Pyelonephritis	

(Include pregnancy within 3 months of death)

Date of operation 5/27/45

Major findings of operation: Pyelonephritis Bilateral Stones, Cystitis

of autopsy: Pathology Section, Gen. Hosp.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sterling A. Leeman M.D.
Address Sinai Hosp Date signed 6/1/45

Stationed : Aberdeen Proving Grounds

G29399 ✓ G29599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Phila
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 741 N. 23rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH GUARDINA

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 11 [illegible]

8. AGE: Years	Months	Days	If less than one day
26			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Guardina
13. Birthplace

MOTHER
14. Maiden Name Mary G
15. Birthplace

16 (a) Informant Capt. Burkholz
(b) Address Aberdeen Proving Grs.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ 4/45 (month) (day) (year)

(c) Cemetery or crematory
Location Phila. Pa.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street

19 (a) JUN 2 1945 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945, at 3:00a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull; Fractures of bones, pelvis and right leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-31-45 at 12:40 A. M. Patterson.
(b) Where did injury occur? Philadelphia Rd. & Eben ezer Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 31 1945

VS 151

G29:00
471328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

X ✓ G29:00
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Greenwood Ave
(If rural give location)
(e) Citizen of foreign country? U S (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Hora

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	widowed

6 (b) Name of husband or wife Emilie Hora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-78

8. AGE: Years	Months	Days	If less than one day
67		7	hr. min.

9. Birthplace Bohemia (town, county, and state)
10. Usual Occupation Soldier Gas Offct.
11. Industry or business Clothing Cutter

FATHER
12. Name John Hora
13. Birthplace Bohemia

MOTHER
14. Maiden Name Maria
15. Birthplace Bohemia

16 (a) Informant Rennda,
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Catonsville Md.

18 (a) Funeral director Frank Brockdorf
(b) Address 900 N. Chester St

19 (a) JUN 2 - 1945 (Date rec'd by Registrar) Registrar Washington Wilkins

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 31 1945 at 9.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945 to May - 31 1945 and that I last saw him alive on May - 31 1945

Immediate cause of death Debilitations
from chronic illness
and mental state
Due to carcinomas rectum

Due to Carcinomas of sigmoid
Other Conditions septicemia, urinary retention, senility
(Include pregnancy within 3 months of death)
Date of operation April 20, 1945 + April 7, 1945
Major findings of operation: Carcinomas sigmoid + secondary metastases
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Runcly M.D.
Address [illegible] Date signed 6-6-45

VS 130

G29401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29401 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Davidson Chemical Co
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Harvey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Christian Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7811

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-1882

8. AGE: Years 63 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Illinois (Town, county and state)

10. Usual Occupation Chief Engineer

11. Industry or business Davidson Chemical

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Sylvia Booth
(b) Address 718 Harvey St

17 (a) Burial (b) Date thereof 6-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St.

19 (a) (b) Huntington Williams M.D.
(Date field certificate received) JUN 2 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31- 19 45 at 9 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed 6-1-45

G29402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95 C ✓ Registered No. G29402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital 25 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3627 Fourth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Padgett Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-21

8. AGE: Years	Months	Days	If less than one day
23	10	13	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Electrician's Helper

11. Industry or business Davidson Chemical Co.

FATHER 12. Name James E. Padgett, Sr.

13. Birthplace Virginia

MOTHER 14. Maiden Name Nelly V. Swaltney

15. Birthplace Virginia

16 (a) Informant Mrs. James E. Padgett

(b) Address 3627 Fourth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Ave

18 (a) Funeral director John F. Denny Inc.

(b) Address 715 Light Street

19 (a) (Date rec'd by registrar) (b) JUN 2 - 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945, at 7:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aortic (Atheromic) Insufficiency

Due to

Other Conditions Hypertrophy of Heart. Chronic Passive Congestion: Ascites
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Thomas J. Mullen M.D.
Medical Examiner.

Date signed June 1, 1945.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

✓ G29403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home + Hospital
(c) Hospital or institution: Broadway + Fairmount
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 l
(e) Length of stay in Baltimore (yrs., mos., or days) 83

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 N. Charles (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Mary Elizabeth Stellwagen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Ernest Stellwagen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-12-1861

8. AGE: Years 83 | Months 5 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Sadtler, C. Columbus
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Brady, Mary E
15. Birthplace Baltimore

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City.

19 (a) JUN 2 - 1945 (Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 10 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945 to May 31 1945, and that I last saw h. alive on May 31 1945

Immediate cause of death	Duration
Carcinoma of ute.	
sigmoid	
Due to	
Due to	
Other Conditions Hypertensive arterio-sclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Marion N. Davis M. D.

Address Church Home Date signed 5-31-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29404

JO #93829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. G29404

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Baltimore City Hospitals 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 704 W. Lafayette Ave. (If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME Berline Stencil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Rufus Stencil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1921

8. AGE: Years	Months	Days	If less than one day
24	-3-	18	.....hr. .....min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER

12. Name James Gorham

13. Birthplace North Carolina

MOTHER

14. Maiden Name Maggie Cherry

15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-'45 (month) (day) (year)

(c) Cemetery or crematory Metem Star

Location Catonsville, Md.

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 3 [illegible] Schroeder St

19 (a) JUN 2-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1945, at 1:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25, 1945, to May 29, 1945, and that I last saw h[illegible] alive on May 28, 1945.

	Duration
Immediate cause of death Pardiac insufficiency	Date ?
Due to Hypertensive cardio vascular disease	7
Due to	
Other Conditions Interstitial nephritis, uremia	10

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at .....M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 6-28-45

937

G29405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TN. 91141

469

Registered No. G29405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months & 15 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 526 Fielen St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARY Mamie White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1896

8. AGE: Years	Months	Days	If less than one day
49	0	9	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Benjamin West (D

13. Birthplace Maryland

MOTHER

14. Maiden Name Eliza Warren (D

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6- 2' 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs Kate R. Wallings

(b) Address 322 N Schroeder St

19 (a) JUN 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30th, 1945 19 , at 1; A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15th 19 44 to May 30 19 45 and that I last saw her alive on May 30th 19 45

Immediate cause of death	Duration
Carcinoma of pancreas with metastasis	?
Due to	?
Due to	
Other Conditions Hypertension	7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. M. Shultz M.D.

Address Balto City Hospt Date signed 5-31-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29406 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4718 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4718 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine B Cavanaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Philip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 12 1862

8. AGE: Years 83 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Patrick Cavanaugh

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Cullen

15. Birthplace Ireland

16 (a) Informant Philip Cavanaugh

(b) Address 4718 York Rd

17 (a) Burial (b) Date thereof 6-4-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore Md

18 (a) Funeral director George A Fayle

(b) Address Fulton & Fayette

19 (a) [illegible] (b) Huntington Williamsport

JUN 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945 at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945 to May 31 1945 and that I last saw h alive on May 31 1945.

Immediate cause of death: Myocardial Insufficiency — Duration: a few

Due to: Myocarditis — 1 year

Due to: Arteriosclerosis — 2 years

Other Conditions: Diabetes Controlled — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 532 E 22nd St. Date signed 6-4-45

G29407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G29407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Aldershot Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Cloney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1878

8. AGE: Years	Months	Days	If less than one day
66	9	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John
13. Birthplace Indiana

MOTHER
14. Maiden Name Catherine Dunbar
15. Birthplace New York

16 (a) Informant Wm C Cloney
(b) Address 604 Aldershot Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (day) (year) 6-4-45
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Geo A Fahey
(b) Address Fulton & Fayette

19 (a) JUN 2 - 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945 to 5-31/1945, and that I last saw h[illegible] alive on 5/31 1945.

Immediate cause of death Multiple lung abscess & acute pneumonitis — Duration

Due to

Due to

Other Conditions Radiation therapy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.
Address St. Agnes Hosp. Date signed 6/3/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

G29:08

CWK-92958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. G29:08

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 1- 26
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Whatcoat Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Mack

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-7085

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle Mack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1912

8. AGE: Years 33 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Daniel Mack (D)
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Sarah Dungion (D)
15. Birthplace: Virginia

16 (a) Informant: Records-Balto. City Hospitals
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/45 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: Md

18 (a) Funeral director: Geo. H. Kelly
(b) Address: 1303 Pressman St

19 (a) (b)
(Date) rec'd by (Local Registrar) Huntington Hillsdale, M.D. Registrar

JUN 2 1945

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH May 31 19 45 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 19 45 to May 31 1945, and that I last saw him alive on May 31 19 45

Immediate cause of death: Pulmonary tuberculosis — Duration: 1 yr

Due to:

Due to:

Other Conditions: T.B. of spleen + liver + intestines
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harold Hillow M.D.
Address: Balto City Hospitals Date signed: 6/1/45

G29409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G29409

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1366 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levi Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Mr

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/1912

8. AGE: Years 32 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Chas. Jones
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Edith Jones
(b) Address 1366 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/45 (month) (day) (year)
(c) Cemetery or crematory Lancaster
Location Lancaster Co. Pa

18 (a) Funeral director Wes. H. Nelson
(b) Address 1303 Pressman St

19 (a) JUN 2 - 1945 (Date rec'd by registrar) (b) Courtesy for Williams M.K. Registrar

VS 151

MEDICAL CERTIFICATION

30

20. DATE OF DEATH June 1, 1945 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to Fracture of Skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/27/45 — 15/2 12:10 P.M.
(b) Where did injury occur? 1300 block N. Milton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed June 1 1945

X

G29410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G29410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Pratt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Harry T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1893

8. AGE: Years 51 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Marion, Va
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name John L. Hitten
13. Birthplace Tipton, Va

MOTHER
14. Maiden Name Mary Devalette Taylor
15. Birthplace Tazewell, Va

16 (a) Informant Harry T. Pratt
(b) Address 2411 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore Co. Md.

18 (a) Funeral director J. Gaston L. Fitzgerald
(b) Address 519 N. Monroe St

19 (a) Date received by Registrar JUN 2 1945 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945, at 8 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 29, 45 to May 30 1945 and that I last saw h[illegible] alive on May 3d 1945.

Immediate cause of death Cardiovascular Disease — Duration 3 and 6 mos.

Due to Hypertension

Due to

Other Conditions Osteosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Higgins M.D.
Address 243 Madison Ave Date signed 6/1/45

G29411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. G29411

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ da
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Parkwyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brodt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1, 1945

8. AGE: Years	Months	Days	If less than one day
			4 hr. 50 min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dale D. Brodt.
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Ickling.
15. Birthplace Balto.

16 (a) Informant Mr. Dale D. Brodt
(b) Address 603 Parkwyn Ave

17 (a) Burial (b) Date thereof 6/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director L. Heimann & Sons
(b) Address 32 S. Broadway

19 (a) (b) Huntington for Baltimore Md
(Deferred by registrar) Registrar

JUN 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1945, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945, to 6/1 1945; and that I last saw him alive on 6/1 1945.

Immediate cause of death	Duration
Multiple Hemorrhage, Blood Dyscrasia	
Due to Probably Erythroblastosis Fetalis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 6/2/45

G29412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29412

FD #93887

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4812 Curtis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Baivous

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife ? (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1904

8. AGE: Years	Months	Days	If less than one day
40	9	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ignasc Polinoks or Polanaks (d)
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof June 4 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anundel County

18 (a) Funeral director Joseph Kasmakes Inc
(b) Address 624 Washington Blvd

19 (a) JUN 2 1945 (b) Huntington Williams, M.D.
(Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945, at 4:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28, 1945, to May 31, 1945, and that I last saw h er alive on May 30, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	(2)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Diabetes Mellitus, Heart insufficiency
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Luis J. Durand M. D.
Address Balto. Md Date signed 6-1-45

VS 180

X

G29413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓ G23113

Registered No. 29413

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Elsinore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltos
(c) City or ~~town~~ Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Elsinore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 11-1872

8. AGE: Years	Months	Days	If less than one day
73	3	22 21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Lewis Kaufman
13. Birthplace Germany

MOTHER
14. Maiden Name Kelly
15. Birthplace

16 (a) Informant Mrs A Goldsmith
(b) Address 2502 Elsinore Ave

17 (a) Burial (b) Date thereof 6/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Balto

18 (a) Funeral director Dan Goodman & Son
(b) Address 1402 Eutaw Pl

19 (a) JUN 3 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 19 5/31 1945
and that I last saw him alive on 5/31 1945

Immediate cause of death Acute Coronary Thrombosis — Duration

Due to Ur Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Homestan M. D.
Address 733 Argyle St Date signed 6/5/45

X

G29414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G29414

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Arlington ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Arlington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Jackson.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-6-1892

8. AGE: Years	Months	Days	If less than one day
53 52	11	26	hr. min.

9. Birthplace Spartanburg S. C.
(Town, County, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Naomi Jackson
(b) Address 310 N. Arlington Ave

17 (a) Burial (b) Date thereof 6-3-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave.

JUN 3 1945 (a) (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945, to June 1 1945, and that I last saw deceased alive on June 1 1945.

Immediate cause of death

Mitral Insufficiency

Due to Hypertension & Nephritis

Antecedent General Edema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Edward Fisher M. D.

Address 1642 Monument E Date signed 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G33415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1746 W. Fairmount Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1746 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Edythe Shenagle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James B. Shenagle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	13	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ralph Hewitt
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabella O'Brien
15. Birthplace Maryland

16 (a) Informant Bernard Shenagle
(b) Address 2152 Lorraine Ave, Woodlawn

17 (a) Burial (b) Date thereof 6-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Schwab
(b) Address 2401 Frederick Avenue

JUN 3 - 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1945 to June 1 1945, and that I last saw her alive on June 1 1945.

Immediate cause of death Coronary Thrombosis — Duration

Due to Mitral Regurgitation

Due to Hypertension

Other Conditions Diabetis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. A. Carlson M. D.
Address 2145-W Belvedere Date signed

92 B

G29416 BALTIMORE CITY HEALTH DEPARTMENT G29416
CERTIFICATE OF DEATH 131a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Miller St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Miller St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Holmes

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-09-2104

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Verna Holmes
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) October 3 1899

8. AGE: Years 45 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Greenbay Va
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Bethelhem Steel Corp

FATHER 12. Name Un Known
13. Birthplace "

MOTHER 14. Maiden Name Lena Oliver
15. Birthplace Va

16 (a) Informant Verna Holmes
(b) Address 1610 Miller St.

17 (a) Burial (b) Date thereof 6 / 3 / 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Greenbay, Va.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brunt Ley Road Lemington for Williams, Md.

19 (a) JUN 2 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

— MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 31 1945, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1945 to 5. 31 1945, and that I last saw h[illegible] alive on 5/26 1945.

Immediate cause of death: Hypertensive cardio-renal disease — Duration: UNK
Due to
Due to
Other Conditions: Mitral insufficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1500 E. Madison St Date signed 6/1/45
Rayner Browne X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29417 — 474366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E — G29417 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4121 Kenniston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman N. Prieur Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-29

8. AGE: Years	Months	Days	If less than one day
16	2	24	hr. min.

9. Birthplace N. Y. (Brooklyn) (Town, county, and state)

10. Usual Occupation Student

11. Industry or business --

FATHER 12. Name Norman N. Prieur

13. Birthplace Va (Norfolk)

MOTHER 14. Maiden Name Kathleen Shaw

15. Birthplace Va

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/2/45 (month) (day) (year)

(c) Cemetery or crematory Elmwood

Location Norfolk, Va.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUN 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 1 - 1945 at 1 o. A M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 24 1945 to June 1 1945 and that I last saw h[illegible] alive on June 1 1945.

Immediate cause of death	Duration
Cardiac failure	Life
Due to Tetralogy of Fallot	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Burch, M.D.

Address J. H. H. Date signed 6-1-45

X

G29418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29418 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3rrd Pressman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3rrd Pressman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Osceola Bobbie Cole

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Husband

6 (b) Name of husband or wife: Charles E. Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1867

8. AGE: Years 78 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Aberdeen, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Bennett Osborne
15. Birthplace Maryland

MOTHER 14. Maiden Name Harriett M. Jackson
15. Birthplace Maryland

16 (a) Informant Harry P. Cole
(b) Address 2422 Louise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4 1945 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Baltimore Md.

18 (a) Funeral director E. Willis Lamoreaux
(b) Address 4510 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 3 VS 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1943, to June 1 1945, and that I last saw her alive on June 1 1945.

Immediate cause of death Cerebral hemorrhage — Duration 3 days

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2424 Brighton Date signed 6-2-45

X

G29419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G29419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3 Feb 45
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kosyjana or Kosiana

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie Kosyjana

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) not known?

8. AGE: Years 65 ? Months Days If less than one day hr. min.

9. Birthplace Russian
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name not known
13. Birthplace Russian

MOTHER 14. Maiden Name not known
15. Birthplace Russian

16 (a) Informant Lillie Kosyjana
(b) Address 208 S. Patterson Park Ave

17 (a) Burial (b) Date thereof June 4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Md.

18 (a) Funeral director John A. Grebhauser Jr.
(b) Address 423 S. Paca St

19 (a) JUN 3-1945 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1945, at 2-30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 6/2/45

G29420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29420 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument st
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isear, Abraham (?)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Charleston S.C.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace

MOTHER 14. Maiden Name Not Known

15. Birthplace

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (b) Date thereof 6-3-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Pikesville Rd

18 (a) Funeral director Jack Levin Inc

(b) Address 1411 E. Baltimore St

19 (a) (b)
(Date received by registrar) Registrar

JUN 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2nd on arrival 19
and that I last saw h alive on 19

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Myocardial failure	
Due to Coronary thrombosis (acute)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute coronary thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Fincher M.D.
M. D.

Address Sinai Hosp Date signed 6-2-45

For C. J. Fukunishi, by Howard J. Carbaugh, MD

G29421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5412

G29421 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cager + Dukeland
(c) Hospital or institution: West Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25d.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2469 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEAH KIRSSIN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace London England (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Morris Carp
13. Birthplace Poland

MOTHER
14. Maiden Name Rachael
15. Birthplace Poland

16 (a) Informant Next Recode
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-45 (month) (day) (year)
(c) Cemetery or crematory Southern Ave
Location Walthy Blvd

18 (a) Funeral director Jack Levi Inc
(b) Address 1439 E. Balto St

19 (a) 1945 (Date filed by registrar) (b) Huntington, W. Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 1945 to 6/1 1945, and that I last saw h[illegible] alive on 6/1 1945.

Immediate cause of death Bronchopneumonia - secondary

Due to Metastatic carcinoma of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Lichenfeld M. D.
Address West Balto. Unit Date signed 6/2/45

G29422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G29422 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wed Springs + Belvedere Ave
(c) Hospital or institution: Levindale Hebrew Home + Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 N. Bentelou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELSON GELFOUND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or wife ~~Ethel~~ Rae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Del. Clerk

11. Industry or business

FATHER 12. Name Nuppie

13. Birthplace Russia

MOTHER 14. Maiden Name Ruth

15. Birthplace Russia

16 (a) Informant Ethel Gelfound

(b) Address 1708 N. Bentelou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location

18 (a) Funeral director Jacob Levin & Bro

(b) Address 1439 E. Balto St

19 (a) 6-1945 (Date filed by registrar) (b)

Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1945, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1945 to 6-1 1945 and that I last saw h~~im~~er alive on 6-1 1945.

Immediate cause of death Carcinoma of colon — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Levin M. D.

Address Levindale Date signed 6/1/45

X

G29423 G29423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Dobler Ave.
(c) Hospital or institution:

9-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Dobler Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHLOE LIEBER CRAIG

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Gallatin Craig
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 12. 1860

8. AGE: Years	Months	Days	If less than one day
84	7	20	hr. min.

9. Birthplace Maryville, Missouri (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Lieber
13. Birthplace Switzerland

MOTHER
14. Maiden Name Renee Cooper Lee
15. Birthplace Butler County, Penna

16 (a) Informant Mr. Albert G. Craig (Son)
(b) Address 2100 Dobler Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 3. 1945 (month) (day) (year)
(c) Cemetery or crematory Maryville Cemetery
Location Maryville Missouri
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) Filed by registrar 1945 (b) Registrar Washington Williams, M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2. 1945 at 9.50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death	Duration
Myocardial Insufficiency	1-10-45
and Heart Block	4-21-45.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Craig M.D.
Address 2055 North Ave Date signed 6/2/45

X

G29424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

Registered No. G29424

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution South Balto. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE MATHIASIS KRELLER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Genevieve Kreller
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) July 18, 1881
8. AGE: Years 63 | Months 11 10 | Days 13 | If less than one day ... hr. ... min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Plumbing Supply
FATHER 12. Name George Edward Kreller
13. Birthplace Balto. Md
MOTHER 14. Maiden Name Elizabeth Fleckenstein
15. Birthplace Balto Md
16 (a) Informant Son - William
(b) Address 1132 Homestead St
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 4/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD.
18 (a) Funeral director Selby & Zecker Sons
(b) Address 403 S. WOLFE ST.
19 (a) 1945 (Date rec'd by registrar) (b) Eugene Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 7 55 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1945 to 5/31 1945 and that I last saw him alive on 5/31 1945.

Immediate cause of death	Duration
Pneumonia	2 Weeks
Typhi Hepatalis	2 "
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John Madison Blythe III M. D.
Address South Bos Sons Date signed 5/31 1945

VS 250

X Hosp

G29425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G29425 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 day
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Grand Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Randolph Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-2647

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1926.

8. AGE: Years	Months	Days	If less than one day
18	10.	24.	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer / Type Tobacco
11. Industry or business Schenuit Rubber Co.

FATHER
12. Name Joseph Richard Brown
13. Birthplace Baltimore

MOTHER
14. Maiden Name Nellie Randolph Morgan
15. Birthplace Virginia

16 (a) Informant Nellie Brown
(b) Address 2003 Grand Ave City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4-1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Catholic) Location Baltimore Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 1945 JUN 3 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31 1945 at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1945 to 5-31 1945 and that I last saw h alive on 5-31 1945.

Immediate cause of death	Duration
C-R failure	
Due to Uremia	
Due to Chronic glomerulonephritis	
Other Conditions Hypertension.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eleanor P. Bass
Address Union Memorial Hosp Date signed 5/31/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29426 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Riverside ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Riverside ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances M. Caswell

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur D. Caswell
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 5, 1882

8. AGE: Years	Months	Days	If less than one day
63	2	27	...hr. ...min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name — Hartlove
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary —
15. Birthplace Balto Md

16 (a) Informant Mrs Irma Nelson
(b) Address 1211 Riversidge ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Balto.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Gorsuch St

19 (a) JUN 7 1945 (b) Registrar Huntington Williams M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1945 at 8:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 2 1945 and that I last saw ... alive on June 1 1945

Immediate cause of death	Duration
Cerebral Apoplexy.	
Due to —	
Due to —	
Other Conditions Cystoscopic Observation. Hypertension. Diabetes Mellitus. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury

23. Signature John C. Schwenck M. D.
Address 1 E. S. Charles St. Date signed 6/2/45

83a

G29427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G29427
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore, Md.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Ridgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Friedberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1520

8. AGE: Years 25 | Months | Days | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Ptak
13. Birthplace Poland

MOTHER
14. Maiden Name Elizabeth Farbosky
15. Birthplace Poland

16 (a) Informant Joseph Haby - Fam. Friend
(b) Address Uniontown, Pa.

17 (a) Removal (b) Date thereof 6/2/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sylvan Hgts. Cem.
Location Uniontown, Pa.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 127 St. Paul Street

19 (a) 3-1945
(Date rec'd by registrar) Huntington Williams M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 45 19..., at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive cardiac failure.

Due to Acute pulmonary edema.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams, M.D.
Medical Examiner.
Date signed June 3, 1945.

G29428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 123

G29428
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6027 Gwynn Oak Ave
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) **FULL NAME** Mrs Sue Thompson (Sue Helen Thompson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stephen I. Thompson
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 27, 1893

8. AGE: Years	Months	Days	If less than one day
52	0 1	5	--hr. ---min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name Herbert Jones
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Ann Pattison
15. Birthplace Maryland

16 (a) Informant Stephen I. Thompson
(b) Address 6027 Gwynn Oak Avenue

17 (a) Burial (b) Date thereof 6/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) JUN 3 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2/1945 at 5:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1945 to 6/2 1945 and that I last saw her alive on 6/1/45 1945

Immediate cause of death Cardiac Failure

Due to Malnutrition

Due to Senility & Exhaustion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. A. Gleary de Chaumont M. D.
Address Date signed

VS 150

G29429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146a

G29429 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 545 Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Thomas Harley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Beatrice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1905

8. AGE: Years 40 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Orderly

11. Industry or business Hospital

FATHER
12. Name Thomas Harley
13. Birthplace Plymouth, N.C.

MOTHER
14. Maiden Name Alma Adams
15. Birthplace Baltimore, Md.

16 (a) Informant Edna Finney
(b) Address 545 Greatman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Orbita Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. D. Hyland
(b) Address 631 Druid Hill Ave.

19 (a) JUN 3 1945 (Date rec'd by registrar) Huntington Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945, at 2:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14, 1944 to May 30, 1945 and that I last saw h alive on May 30, 1945.

Immediate cause of death	Duration
Carcinoma of Gl. esophagus	9 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. L. Campbell M. D.
Address 630 N. Carey St. Date signed 6-2-45

VS 150

G29430 LORETTA KAY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G29430 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Lindsay Ln
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 11 - 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Lindsay Ln (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta Kay

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/31/42

8. AGE: Years	Months	Days	If less than one day
1			hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Dewey Kays
13. Birthplace Va

MOTHER
14. Maiden Name Dorothy Barnes
15. Birthplace Md

16 (a) Informant Dorothy Barnes
(b) Address 1016 Lindsay Ln Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date of burial (month) (day) (year) June 3 1945
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director A Halstead Dudderell
(b) Address 915 Huntington Ave

JUN 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3/1945 1945 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/45 19 to 6/3/45 19, and that I last saw h[illegible] alive on 6/4/45 19.
Immediate cause Bronchial Pneumonia — Duration 3 days
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
Autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. Lincoln Sellers M. D.
Address [illegible] Date signed 6/5/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29431
AB-93649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

G29431
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Burroughs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1902

8. AGE: Years	Months	Days	If less than one day
43	5	0	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Allen Fountain (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Spencer (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof June 5 1945 (day) (yr.)
(c) Cemetery or crematory Mount Lotus
Location

18 (a) Funeral director A. Hahn
(b) Address 918 E. Fayette

19 (a) JUN 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1- 1945, at 10.15

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16- 1945, to 6-1- 1945.
and that I last saw h er alive on 6-1- 1945.

	Duration
Immediate cause of death Lobar pneumonia	3 days
Due to	
Due to	
Other Conditions Carcinoma of rectum ? with metastasis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Houck E. Dalton
Address Balt. City Hosp. Date signed 6/2/45

108

G29432 ✓ G29432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Etting Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1897

8. AGE: Years 47 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Day's work

11. Industry or business

FATHER
12. Name Charles Renby
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John Carter
(b) Address 1804 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-45 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location

18 (a) Funeral director A. Hahlot
(b) Address 1 S Broadway

JUN 4 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1945, at 1 30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Arteriosclerotic cardiovascular-renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury , at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 1 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G29433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/ 3 B

Registered No. G29433

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman Seeger

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nettie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1867

8. AGE: Years 77 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Retired

FATHER
12. Name William Seeger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Nettie Seeger
(b) Address 1914 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St. Balto., Md.

19 (a) Filed by registrar (b) Registrar

JUN 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19 45 to June 1 19 45, and that I last saw h[illegible] alive on June 1 19 45

Immediate cause of death	Duration
Acute Myocarditis	days
Due to Pulmonary Tuberculosis, chronic	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Palm Rondeau
Address 1012 Edmondson Date signed 6/4/45

X

G29434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G29434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lemuel Hospital 47
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred O. McCrea

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE	Years	Months	Days	If less than one day
Abst	68			hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Jos. E. Landry
(b) Address 2 E. Lexington St
17 (a) Removal (b) Date thereof 6/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Erie
Location Erie, Pa.
18 (a) Funeral director Tillson & Son Inc
(b) Address 1217 E. Fayette St
19 (a) JUN 4 - 20 (b) Huntington, W. Va.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 1945, at 0 est. AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardio-Vascular Renal Disease

Due to

Other Conditions Asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Anders M.D.
Medical Examiner.
Date signed 5-30-45

VS 151

G29435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29435

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helene Leubecker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife John C Leubecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 - 1859

8. AGE: Years 85 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Bruckner
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fleischmann
15. Birthplace Germany

16 (a) Informant Elizabeth Leubecker
(b) Address 224 N Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) Date rec'd JUN 9 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1. 1945 at 5 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945 to June 1 1945 and that I last saw h[illegible] alive on May 31 1945

Immediate cause of death Chronic myocarditis — Duration 5/27/45
Due to arterio-sclerosis —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Krenmann M. D.
Address 722 N. Kenwood Date signed 6/6/45

G29436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164

Registered No. G29436

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Prestmann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FERD WARNKEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanor Warnken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1884

8. AGE: Years	Months	Days	If less than one day
60	7	23	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Wachter Hospkin Russel

FATHER
12. Name John Ferd Warnken
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Berlincke
15. Birthplace Unknown

16 (a) Informant Mrs. Eleanor Warnken
(b) Address 3021 Presstman St.

17 (a) Burial (b) Date thereof 6/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Wash. Blvd.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 1 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1945, at 10:50 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound
7 Head

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-1-45 at 12:05 P. M.
(b) Where did injury occur? 3021 Prstmann S.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Shot self

23. Signature Robert L. Bratton M.D.
Medical Examiner.
Date signed June 2 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G29437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29437

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Romoser

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1852

8. AGE: Years	Months	Days	If less than one day
93	1	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Mathias Romoser
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Mrs. Edna Johnston, niece
(b) Address 1822 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 1 - 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to May 29 1945, and that I last saw her alive on May 29 1945.

Immediate cause of death: Arteriosclerotic C-V disease — Duration: 8 yrs
Due to
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Lombardi M. D.
Address 632 S Bonnaville Rd signed 6/2/45

X

G29438 ✓ G29438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Gold St
(c) Hospital or institution: 15'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Joseph Cook Custis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 - 1945

8. AGE: Years | Months | Days | If less than one day: 8 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Custis
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lillian Lee
15. Birthplace Baltimore Md

16 (a) Informant Lillian Custis
(b) Address 701 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4 - 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location West Port

18 (a) Funeral director J. E. Brooks
(b) Address 1463 N. Carey St

19 (a) JUN 4 - 1945 (Date received by city registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1945 to June 2 1945 and that I last saw him alive on June 2 1945

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Blohits M. D.
Address 1543 Penna Ave. Date signed 6-4-45

VS 8

G29439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.of
(b) Street address 2018 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chas. Scholtz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married~~, widowed, ~~or divorced~~. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John P. Schultz
13. Birthplace Md

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Leonard P. Schultz
(b) Address 1506 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6th 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Comm.
Location E. North Ave. Ext.

18 (a) Funeral director Leo G. Leo Cook
(b) Address 1201-03 N Patterson Park Ave

19 (a) JUN 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1945 at 9:20 P M

21. I certify that I took charge of the remains described above, held an Inspection-Interview and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C. V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Feldmeier M.D.
Medical Examiner.
Date signed 6/3/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29410 ✓ G29410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 E Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 E Lombard St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Katherine Wolfenman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 18th 1874

8. AGE: Years 70 | Months 9 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Antone Huber

13. Birthplace Germany

MOTHER 14. Maiden Name Rose Dingle

15. Birthplace Germany

16 (a) Informant Margaret Schmink

(b) Address 3519 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6th 1945 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Road

18 (a) Funeral director Leo G. Leach

(b) Address 1701-03 N Patterson Park Ave

19 (a) JUN 4 (Date received by Registrar) (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2nd 1945, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944, to June 2 1945, and that I last saw h.. alive on June 1 1945.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Chr. Myocarditis	12-15-44
Due to Myocardial failure.	5-25-45
Due to	
Other Conditions Cancer	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence None at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature E A Schmink M. D.

Address 842 S Ellwood Ave Date signed 6-4-45

VS 150

X

G29441 BALTIMORE CITY HEALTH DEPARTMENT G29441

CERTIFICATE OF DEATH 940 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 N Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John. T. Mulligan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1886

8. AGE: Years 58 59 | Months 9 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James E Mulligan
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Augusta E Kalb
15. Birthplace Baltimore Md

16 (a) Informant James E Mulligan
(b) Address 909 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd.

18 (a) Funeral director John E Mozan
(b) Address 3000 E Baltimore St

19 (a) JUN 4 - 1945 (Date received by registrar) Registrar

Forwarding for Middletown, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945, to June 1 1945, and that I last saw h. alive on June 1 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 7 months
Due to: Coronary sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A B Kelly M. D.
Address 100 N Lemmon Ave Date signed June 2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Holbrook Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Holbrook Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY WILHELMINA TREFF

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gudthardt G. Treff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1877

8. AGE: Years 68 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Klatz
15. Birthplace Germany

16 (a) Informant Carlton Treff - Son
(b) Address 2104 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) JUN 4 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION P.M

20. DATE OF DEATH June 1, 1945, at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 1 1945, and that I last saw her alive on June 1 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. H. Krenger

Address 1402 E. Lanvale Date signed 6-4-45 M. D.

Approved: Howard J. Bradley M.D. per Robert Lee Sutton M.D. 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29443 ✓ G29443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 E. 22nd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAWLEY DOUGLAS CARY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	215-10-3139

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Irene M. Ningard
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug. 19. 1878

8. AGE: Years	Months	Days	If less than one day
66	9	13	hr. min.

9. Birthplace Chatham Va.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John William Cary
(b) Address 5514 Selma Ave.

17 (a) Burial (b) Date thereof June 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) JUN 4 - 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2. 1945 at 3.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1- 1945 to June 2- 1945, and that I last saw him alive on June 2 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day.
Due to Arterio-Sclerosis -	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed June 2-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

G29444 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenspring + Belvedere
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring + Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FANNIE DE BEER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elias Gutfreund
13. Birthplace Austria

MOTHER
14. Maiden Name Katie
15. Birthplace Austria

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Eglain Rd

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Balto St

19 (a) (Date filed in registrar's office) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 7.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1944 to 6-2 1945 and that I last saw h[illegible] alive on 6-4 1945

Immediate cause of death: Bronchopneumonia
Second due to hemiplegia
Due to
Due to
Other Conditions Hemiplegia
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M. D.
Address Levindale Date signed 6/3/45

VS 150

G29445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G29445 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4851 Leistertown Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)

(d) Street No. 4851 Leistertown Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME June Lois Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18-1933

8. AGE: Years 12 | Months 11 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER 12. Name Meyer

13. Birthplace Balto

MOTHER 14. Maiden Name Ida nee Krakow

15. Birthplace Balto

16 (a) Informant Meyer Kramer

(b) Address 445 Reid St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)

(c) Cemetery or crematory Shaarai Shomayim

Location

18 (a) Funeral director Jos Levin Inc

(b) Address 1420 E. Balto St.

19 (a) JUN 4 1945 (Date rec'd by registrar) (b) Huntington Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4-45 19 at 2:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to June 1945 and that I last saw h[illegible] alive on 6-3 1945

Immediate cause of death: Chronic Myeloid Leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lucile Wesley

Address 1739 Eutaw Date signed 6-4-45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V - G29446

1510 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Ausgmuth St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Augmuth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E Shettle

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Walter E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 15 1883
8. AGE: Years 62 | Months 1 | Days 16 | If less than one day hr. min.
9. Birthplace: Baltimore Co Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Theodore A Ries
13. Birthplace: Towson Md

MOTHER
14. Maiden Name: Anna E Hoffman
15. Birthplace: Carroll Co Md

16 (a) Informant: Theodore A Ries
(b) Address: 1510 Augmuth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore Md

18 (a) Funeral director: William Cook Jr
(b) Address: 1217 E Pont St

19 (a) JUN 4 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1945, to June 1, 1945, and that I last saw h[illegible] alive on June 1 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days
Due to: Arteriosclerotic Cardiovascular Renal Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Edward A Wolfe
Address: 1331 E Northern Date signed: 6-2-45

VS 150

G29447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 G29447 Registered No. L4747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 2730

(b) Street address 2730 ~~3027~~ Booker Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2730 ~~3027~~ Booker Drive (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Annie Jerry

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Married

6 (b) Name of husband or wife Junius Jerry

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 1911

8. AGE: Years	Months	Days	If less than one day
34	1		hr. min.

9. Birthplace Charlotte N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Davis

13. Birthplace Newbury S C

MOTHER 14. Maiden Name Ida Higgins

15. Birthplace Newbury, S.C.

16 (a) Informant Husband Henry Jerry

(b) Address 2730 ~~3027~~ Booker Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUN 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945 at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to May 31 1945 and that I last saw h-r alive on May 31 1945

Immediate cause of death Cardiac Decomp. — Duration 3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ronald Bibighaus M. D.

Address 501 Cherry Hill Rd Date signed 6/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29448 ✓ G29448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4416 Eastway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 Eastway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	1	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Neeb
13. Birthplace Germany

MOTHER
14. Maiden Name Marie A. Travers
15. Birthplace France

16 (a) Informant Mrs. A. M. Edyvean
(b) Address 4416 Eastway,

17 (a) Burial (b) Date thereof 6/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JUN 4 - 1945 Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1945, at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939, to June 3 1945, and that I last saw h[illegible] alive on June 2 1945.

Immediate cause of death — Duration
carcinoma of Tongue — 4 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 1720 Eutaw Pl Date signed 6/3/45

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G29449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. G29449

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 N. Brice Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Brice Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN J. LOUIS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-03-9629

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha M. Horton

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 5, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	26	....hr. ....min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business Baltimore Butchers

FATHER
12. Name John Louis
13. Birthplace France

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Bertha Louis
(b) Address 518 N. Brice

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Gwynn Oak Ave

18 (a) Funeral director Thos. J. Kenny
(b) Address Tolin & Gilmore

19 (a) JUN 4 - 1945 (Date received by registrar) Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5, 1945, to May 31, 1945, and that I last saw him alive on May 31, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Edgar A. Kemp

Address 3030 Edmondson Ave. Date signed M. D. 6/2/45

X

629450

AB-93824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

629450 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Petraskas or Frank Petrauskas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 18- 1894

8. AGE: Years 50 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Petraskas or Petrauskas
13. Birthplace ?

MOTHER
14. Maiden Name Annie ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-45
(month) (day) (year)
(c) Cemetery or crematory Redamer
Location Blair Rd.

18 (a) Funeral director Thos J Kenny
(b) Address Hillen & Gilman

19 (a) Date received by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1- 1945, at 3.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25- 1945 to 6-1- 1945 and that I last saw him alive on 6-1- 1945

Immediate cause of death: Peritonitis

Due to: Pneumonia — Duration: 6-7 Days

Due to: Diverticulitis sigmoid — ? 1 week

Other Conditions: Cardiac decompensation — 6 Days
(Include pregnancy within 3 months of death)

Date of operation 5-25-45

Major findings of operation: Diverticulitis sigmoid with peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 6-2-45

X

G29451 Certificate 1573 Vol 160 G29451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1071 Kimball Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1071 Kimball Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Ross

3 (b) If veteran, name war
3 (c) Social Security Account No. 235-16-0198

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife WILMA STARN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1889

8. AGE: Years 55 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Ohio (town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Drawn Stock Lumber mill

FATHER
12. Name James Ross
13. Birthplace Ohio

MOTHER
14. Maiden Name Laura Montgomery
15. Birthplace Ohio

16 (a) Informant Wilma Ross
(b) Address 1071 Kimball Court

17 (a) Burial (b) Date thereof 6/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Pulaski Highway

18 (a) Funeral director Lowe & Stephenson
(b) Address 31 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 4 - 1945

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Febr 11 1945 to Febr 20 1945, and that I last saw h[im] alive on Febr. 20 1945.

Immediate cause of death coronary occlusion, heart failure — Duration

Due to sclerosis of the arteries, high blood pressure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Neuhauser M. D.
Address 914 Patapsco Ave. Date signed 6-3-45

G29452 BALTIMORE CITY HEALTH DEPARTMENT G29452

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 S.REGISTER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD? (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S.REGISTER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK HALEY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: AUGUSTA HALEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 3 1870

8. AGE: Years 74 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name JOSEPH HALEY
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant EDWARD HALEY (SON)
(b) Address 1115 ENDSOR ST.

17 (a) BURIAL (b) Date thereof JUNE 4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory TRINITY
Location ODONNELL ST.

18 (a) Funeral director Tilley & Zeile Inc
(b) Address 403 S. WOLFE ST.

19 (a) JUN 4 1945 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 1945 at 1/10 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1945 to 6/1 1945, and that I last saw h[illegible] alive on 6/1 1945

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Kurkowski M. D.
Address 1016 S. East Ave Date signed 6/3/45

Mitchell F. Kurkowski

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29453 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3309 ODONNELL ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 ODONNELL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARTHA I. TOLAND

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: DANIEL TOLAND

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JAN. 21 1901

8. AGE: Years 44 | Months 4 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: WILLIAM BROWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: MARY M. HUMMEL
15. Birthplace: BALTO. MD.

16 (a) Informant: DANIEL TOLAND (HUS.)
(b) Address: 3309 ODONNELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 4/45 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE? EXT.

18 (a) Funeral director: Lilly & Zacks Chas.
(b) Address: 403 S. WOLFE ST.

19 (a) ..... (Date rec'd by Registrar) (b) ..... Registrar

JUN 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 1945, at 12/30 PM.

21. I certify that death occured on the date above stated; that I attended deceased from April 12 1945, to June 1 1945, and that I last saw h[er] alive on June 1 1945.

Immediate cause of death: Hypertensive Cardio-Vascular Renal

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. Tolliver S. Hummel M. D.
Address 1076 S. Ext Ave Date signed 6/2/45

Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1952

G29454

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: 1449 Key Highway
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 YEARS

2. USUAL RESIDENCE OF DECEASED: Sparrows Pt
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Wells Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugo Vitzenti

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: RUTH VITZENTY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 16 1908

8. AGE: Years 36 | Months 6 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual Occupation ELECTRICIAN.

11. Industry or business SHIP YARD

FATHER
12. Name GOTLEIB VITZENTY
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARIE ZEISKA
15. Birthplace GERMANY

16 (a) Informant RUTH VITZINTY (WIFE)
(b) Address 2906 WELLS AVE. SPARROWS POINT

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 7/45 (month) (day) (year)
(c) Cemetery or crematory RICHLAND CEM.
Location SUMMERSET CO. PENNA.

18 (a) Funeral director Silby + Zilen Sons
(b) Address 403 S. WOLFE ST.

19 (a) JUN 4 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1945, at 3 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/2/45 at 10:34 A. M.
(b) Where did injury occur? 1449 Key Highway.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes.
(d) Means of injury Piece of wood fell + struck him.

23. Signature Howard R. Mahood M.D.
Medical Examiner.
Date signed June 3, 1945.

VS 151

G29455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29455

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 N. Montford Avenue
(c) Hospital or institution: 61
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hanheide

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: Henry Hanheide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 9, 1873

8. AGE: Years 71 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace --
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant James Clabaugh
(b) Address 103 N Montford Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUN 4 - 1945 (b) [illegible] Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to June 3 1945 and that I last saw h[illegible] alive on June 3 1945

Immediate cause of death: Cardio-vascular renal disease — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar Zeller, M.D.
Address 2739 Eastern Ave Date signed M 6 D 4/45

(over)

G29456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G29456

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 N. Brice St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Brice St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Indiana Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Edgar R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27, 1887

8. AGE: Years 57 | Months 6 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John Askew.

13. Birthplace —

MOTHER 14. Maiden Name Indiana —

15. Birthplace —

16 (a) Informant Mrs. Ethyl R. Day

(b) Address 530 N. Brice St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6.4.45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 E. Monument St

19 (Date received by Registrar) JUN 4 - 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945, to June 2 1945, and that I last saw h[illegible] alive on June 1 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension	
Due to	
Other Conditions Hypertensive cardio-vascular Renal disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Thornton Lee M. D.

Address 601 N. Monument St Date signed June 2 1945

G29457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

Registered No. G29457

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Penna. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Penna ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Evans

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0727

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) 5-25-1909

8. AGE: Years	Months	Days	If less than one day
44	2 0	8	hr. min.

9. Birthplace Farmville, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Evans
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie Stokes
15. Birthplace Va.

16 (a) Informant Maggie Smith
(b) Address 1008 Penna ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location a.a. County Md.

18 (a) Funeral dir. Wellington A Jackson
(b) Address 916 Penna ave

19 (a) JUN 4 1945 (Date rec'd by Registrar) (b) Huntington Hitch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 45, 19..., at ...M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Aortic Valve Disease
(Duration)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D. (Medical Examiner.)
Date signed 6-4-45

VS 151

G29458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 G29458 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ days) 10 Y
(e) Length of stay in Baltimore (yrs., mos., or days) + +

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Middleton Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME ~~JOHNS HOPKINS HOSPITAL~~ Eugene T. Eichelberger

3 (b) If veteran, name war No

3 (c) Social Security Account No. 215-01-7644

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Gertrude Eichelberger

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 1-31-92

8. AGE: Years 53 | Months 4 | Days 1 | If less than one day ....hr. ....min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Chemical Co.

11. Industry or business

FATHER 12. Name Samuel Eichelberger
13. Birthplace Md

MOTHER 14. Maiden Name Laura Turner
15. Birthplace Va

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) JUN 4 1945 (Local registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1945 to June 2 1945 and that I last saw he alive on June 2 1945.

Immediate cause of death	Duration
Heart Failure	1 wk
Uremia	1 wk
Due to Coronary Occlusion	11 yrs
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....

23. Signature [signature] M.D.
Address Johns Hopkins Hosp. Date signed 6/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G29459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 S Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 345 S. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Bludis
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-03-0043

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Married

6 (b) Name of husband or wife John J. Bludis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 12, 1917

8. AGE: Years	Months	Days	If less than one day
28	1	19	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CLERICAL WORK
11. Industry or business BTO. RR.

FATHER
12. Name ANDREW ZURAS
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name Anna Putzeitemie
15. Birthplace Lithuania

16 (a) Informant ANN GAIDES
(b) Address 401 S. FREMONT ST.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd
18 (a) Funeral director Charles W. Kuchenbecker
(b) Address 637 Washington Blvd
19 (a) (Date received by registrar) JUN 4 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1945, at 5:35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945, to June 1, 1945, and that I last saw her alive on June 1, 1945.

Immediate cause of death	Duration
Rheumatic Fever	9 mos.
Subacute Bacterial Endocarditis	8 wks.
Due to Cerebral Embolism	2 days.
Due to	
Other Conditions Mitral Stenosis & insufficiency	Embo-

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Earl Pass, M.D.
Address 400 Wilkens Ave Date signed 6-1-45 M. D.

58E

A40844

G29460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 30F

G29460

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 2 Box 5-51
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-45

8. AGE: Years | Months: 1 | Days: 25 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Little
13. Birthplace Md.

MOTHER
14. Maiden Name Burnett Cromwell
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 5 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brydsneck
Location L. B. Co

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18- 1945, to 6-3- 1945 and that I last saw h[illegible] alive on 6-3- 1945

Immediate cause of death: Congenital Syphilis — Duration: 7½ wks
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Abell M. D.
Address J. H. A. Date signed 6-7-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G29461 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2543 Greenmount
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b)
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Francis H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1870

8. AGE: Years 74 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Timothy Ward
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Tighe
15. Birthplace Ireland

16 (a) Informant Mrs. Smith
(b) Address 2543 Greenmount ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral 6/5/45
Location Balto, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 JUN 4 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1/45 19 , at 11 P

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27/1944 to 6/1/45 19 , and that I last saw h er alive on 6/1/ 19 45.

Immediate cause of death Hypertensive cardio vascular disease — Duration 1½ yr

Due to Diabetes Mellitus — Duration 11 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Harry Deibel M. D.

Address 126 Hanover St Date signed 6/4/1945

X

G29462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G29462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Haywood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN -4 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1945 12 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/25/45 about 3/1 2 30 P M.
(b) Where did injury occur? 1510 E. Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Fell down steps

23. Signature C. J. Pelhimbe M.D. Medical Examiner.
Date signed 6/27/45

141

X

G29463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G29463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 149 N. HIGH STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenow V. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 4 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUN -4 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1945, at 10 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/24/45 at 10:35 P.M.
(b) Where did injury occur? Low & Norrent Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Walker M.D. Medical Examiner.
Date signed 5-25-45

2140 X

G29464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G29464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Gardenview Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Burly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1 day	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Burly
13. Birthplace Berwick Pa

MOTHER
14. Maiden Name Nellie Grasmiff
15. Birthplace Berwick, Pa

16 (a) Informant Mother
(b) Address 911 Gardenview Drive -21

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 4 1945 Hamilton Williams, M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26, 1945 to May 30, 1945. and that I last saw h.e.r alive on May 30, 1945

Immediate cause of death Pneumothorax

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oscar Hartman, M.D.
Address 2231 Eutaw Pl Date signed 5/31/45

1943

G29465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G29465 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Monument & Eutaw Sts

(b) Street address ~~Lafayette Market~~

(c) Hospital or institution: Sinai Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Labarles Madeira St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Patricia May Brandenburg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 day | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Louis Brandenburg

13. Birthplace Akron Ohio

MOTHER 14. Maiden Name Edith F Kay

15. Birthplace Boonsville Ky

16 (a) Informant Mother

(b) Address Labarles & Madeira St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 4 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN - 4 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 1140 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1945 to 5/25 1945 and that I last saw h.e.r alive on 5/25 1945.

Immediate cause of death: Atelectasis

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William F Luman M. D.

Address 1716 Eutaw Place Date signed 5/28/45

VS 2

1-142

X

G29466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G29466 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fourteen Cabin Creek Hts.

(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4635 - Harford Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George A. Mueller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife Helen R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-1884

8. AGE: Years	Months	Days	If less than one day
60	11	19	hr. min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Mueller

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Geanor Hff.

15. Birthplace Pennsylvania

16 (a) Informant Mrs E. Mellerson

(b) Address 2012 - Ward St.

17 (a) Burial (b) Date thereof 6-6-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto -

18 (a) Funeral director Leonard J. Luck

(b) Address 5305 Harford Road

19 (a) (b) Huntington Woods Md

(Date rec'd by registrar)

JUN 4 1945

VS-190 5

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 5-45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Pulmonal Circulatory Failure

Due to Probably Generalized Arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature D. F. Coffin

Address Mercy Hosp. Date signed 6/3/45

Dr. G29467 G29467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3327 Rueckert Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3327 Rueckert Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Frances E. Blum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Joseph Blum
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Riley
15. Birthplace Md.

16 (a) Informant Mrs. Frances E. Blum
(b) Address 3327 Rueckert Avenue

17 (a) Burial (b) Date thereof 6/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 (a) JUN 4 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to 5/30 1945 and that I last saw him alive on 5/30 1945.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Tyler Gilley M. D.
Address 5703 Harford Rd Date signed 6/4/45

VS 150

G29468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1114E

Registered No. G29468

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: Sinai Hospital 8-1

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3423 Parklawn Avenue
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** John James Hull

3 (b) If veteran, name war.....

3 (c) Social Security Account No.....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of ~~husband~~ or wife Elizabeth (nee Rachuba)

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	11	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business Pa. R. R.

FATHER
12. Name Joseph Aull
13. Birthplace unknown

MOTHER
14. Maiden Name Elizabeth Pausch
15. Birthplace unknown

16 (a) Informant Mrs. Elizabeth Aull
(b) Address 3423 Parklawn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/45 (month) (day) (year)

(c) Cemetery or crematory ~~XXXX~~ St. Stanislaus
Location Mt. Carmel Rd. Baltc. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by Registrar) JUN 4 1945 (b) Washington Heights

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2 1945, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1945 to 6-2 1945, and that I last saw him alive on 6-2 1945.

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Pneumothorax,	
Due to Left, Spontaneous	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Av Aprx

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature W. L. Arnett M. D.

Address Sinai Hosp Date signed 6-2-45

X

G29469 Weiseth

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 9 ✓ G29469 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A. Co
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Annapolis Rd. (If rural give location)
(e) Citizen of foreign country? Md (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Florence Ann Clayton ~~CLAYTOR~~

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female colored | 5. Color or race | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - 12 - 45

8. AGE: Years | Months: 2 | Days: 20 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Thomas Clayton

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Mary Crawford

MOTHER 15. Birthplace Va

16 (a) Informant Recorder

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co.

18 (a) Funeral director A. Howard Evans

(b) Address 1400 N. Eutaw St.

19 (a) (Date received by registrar) JUN 4 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945 at 4 13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1945 to June 2 1945 and that I last saw h[illegible] alive on June 2 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to: Bronchiolitis — 1 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren M. X Weiseth M. D.

Address [illegible] Date signed 6-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G29470 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 N Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Carr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-1922

8. AGE: Years 22 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Golden Bruce

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name Katie Cook.

MOTHER 15. Birthplace Va

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 6-5-45 (month) (day) (year)

(c) Cemetery or crematory Cambridge, Md

Location

18 (a) Funeral director Mrs Geo H. Holland

(b) Address 631 Edmondson Ave

19 (a) 1945 (Entered by registrar) Huntingtown Williamsport, Md

JUN

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 4.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 2 1945, and that I last saw him alive on June 2 1945.

Immediate cause of death Uremia — Duration ? 2 weeks

Due to ? Malignant nephrosclerosis
? Lymphosarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert A. Kattus

Address Johns Hopkins Hosp Date signed 6/3/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G29471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G29471

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 E. 27 St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 E. 27 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis H. Fager

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1912

8. AGE: Years 32 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank H. Fager
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mary C. Whitty
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary C. Fager.
(b) Address 331 E. 27 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date received by registrar) (b) Registrar

JUN 6 1945

Hamilton for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1945, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1945 to 6/1 1945 and that I last saw h alive on 5/31 1945.

Immediate cause of death Cardiac hypertrophy & myocardial insufficiency — Duration 3 yrs. of disease

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton

Address 3963 Greenmount Ave. Date signed 6/4/45 M.D.

X

WE 180

G29472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G29472 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 S. East ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. East ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary. Harris.

3 (b) If veteran, name war: no.

3 (c) Social Security Account No.: no.

4. Sex: Female. | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Amos. Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1911

8. AGE: Years 34. | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Packing House

11. Industry or business

FATHER 12. Name John. Lipkowski

13. Birthplace Poland.

MOTHER 14. Maiden Name Mary. Sarpapski

15. Birthplace Poland

16 (a) Informant Georgina Young

(b) Address 801. E. East ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Wendell. Hippel

(b) Address 312 S. Highland ave

19 (a) Date received by Registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5- 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1945, to 6-5 1945; and that I last saw h alive on 6-5 1945.

Immediate cause of death: Carcinoma of cervix — Duration: 3 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Davidson M. D.

Address 3218 Eastern Date signed 6-7-45

(OVER)

G29473
472924

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29473
CERTIFICATE OF DEATH 55E
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre De Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Quinlin Haley.
3 (b) If veteran, name war —
3 (c) Social Security Account No. 219-16-8596

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 11-1-24
8. AGE: Years 20 | Months 7 | Days 2 | If less than one day ..... hr. ..... min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Coal Driver
11. Industry or business

FATHER
12. Name John Haley
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Pugh
15. Birthplace Va

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 1945 (month) (day) (year)
(c) Cemetery or crematory Wesleyan Chapel
Location Harford Co. Md.
18 (a) Funeral director R. Madison Mitchell
(b) Address Havre de Grace Md.
19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar
JUN 5 1945 Washington Headquarters, D.C.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH June - 3 1945 at 9.42 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945 to June 3 1945 and that I last saw him alive on June - 3 1945.

Immediate cause of death Disseminated Sarcomatosis of unknown origin. — Duration .....
Due to ..... — .....
Due to ..... — .....
Other Conditions ..... — .....
(Include pregnancy within 3 months of death)
Date of operation ..... — .....
Major findings of operation: ..... — .....
of autopsy: Sarcomatosis — .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature. Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 6/4/45

X

G29474 ✓ G29474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1248 Washington Boulevard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia May Eavey

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joseph A. Eavey

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 20. 1885

8. AGE: Years 60 | Months 0 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Conrad G. Rapp
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Emma Airey
15. Birthplace Balto Md.

16 (a) Informant Joseph A. Eavey
(b) Address 1248 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6. 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mr. & Mrs. John M. Taufel & Son
(b) Address 801 W. Fayette St.

19 (a) (Signature of undertaker) (b) Huntington Williams, M.D. (Address) 1248 Washington Blvd (Date signed) 6/4/45

JUN 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1941, to 6/3 1945, and that I last saw her alive on 6/3 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 2da

Due to: Hypertensive Cardio Vascular Blood Disease — Duration: 4yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G. Lankenau M.D. 1248 Washington Blvd (Address) (Date signed) 6/4/45

629475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

629475 Registered No. 170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Pier Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Sparks CHARLES C. SPARKS

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married –

6 (b) Name of husband or wife Nessie L. Sparks

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1906

8. AGE: Years 38 | Months 7 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Moravian Falls, N. C.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Md Dry Docks

FATHER
12. Name Millard Sparks
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Pearson
15. Birthplace N. C.

16 (a) Informant Jessie L. Sparks
(b) Address 1300 Pier Court Brooklyn

17 (a) Removal (b) Date thereof June 5 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Shady Grove Cemetery
Location Wilkes Co. N. C.

18 (a) Funeral director Mrs. John W. Tenful & Son

(b) Address 804 W. Fayette St

19 (a) JUN 5 - 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4-1945, at 5:05 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Subarachnoid Hemorrhage
Due to Bronchopneumonia

Other Conditions Multiple contusions + fractures. Contusion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/6

(a) Date of injury 5-31-45 at 12:42 A. M.

(b) Where did injury occur? Frankfurt, 800' W of Tudor Co

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 6-4-45

VS 151

G29476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29476 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 N. Curley
(c) Hospital or institution:

6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Curley
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Biagio Girlando

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-10-3258

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Noemi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1889

8. AGE: Years	Months	Days	If less than one day
56	1	2	hr. min.

9. Birthplace Comiso Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Tailor Shop

FATHER
12. Name Giuseppe Girlando
13. Birthplace Italy

MOTHER
14. Maiden Name Nunziata Di Stefano
15. Birthplace Italy

16 (a) Informant Noemi Girlando (Wife)
(b) Address 410 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Daniel Dallahan
(b) Address 52 N. Morley St.

19 (a) JUN 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to 6-3 1945, and that I last saw h~~im~~ alive on 6-3 1945.

Immediate cause of death	Duration
Coronary Thrombosis	6-3-45
Due to —	
Due to —	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence E. Lee
Address 11 E. Chase St Date signed 6/5/45

X

G29477 BALTIMORE CITY HEALTH DEPARTMENT ✓ G29477

CERTIFICATE OF DEATH 940

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 E. 20th St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 E 20-St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry ~~Henry~~ Schlasbo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Wht | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or ~~wife~~ Agnes S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1865

8. AGE: Years 79 | Months 9 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Henry Schlasbo
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Baltimore Md

16 (a) Informant Karl C Andrae
(b) Address 6004 Bellona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3600 E Baltimore St

19 (a) (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

JUN 5 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1944 to June 2, 1945 and that I last saw h~~im~~ alive on May 25, 1945.

Immediate cause of death Coronary occlusion

Duration ?

Due to

Due to

Other Conditions Cerebral arteriosclerosis — 14 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Guyton
Address 3983 Beaumont Ave. Date signed 6/4/45

G29478 — 1 v — G29478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Baltimore Elliott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rogers Ave. Ell. City
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mabel Weigand

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank Weigand

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1897

8. AGE: Years 47 | Months 10 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Ellicott City Md.
(Town, county, and state)

10. Usual Occupation At home.

11. Industry or business

FATHER
12. Name J.W. Hellenriger
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Krapt
15. Birthplace Maryland

16 (a) Informant Mrs. F. Kerr
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7, 1945 (month) (day) (year)
(c) Cemetery or crematory St Johns.
Location Ellicott City Md

18 (a) Funeral director J.C. Deginhardt
(b) Address Ellicott City Md

19 (a) JUN 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1945 at 1.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1945 to 6/4 1945 and that I last saw her alive on 6/4 1945

Immediate cause of death Uremia

Due to Carcinomatosis

Due to Carcinoma of Cervix

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Howard W Stier

Address St Agnes Hosp. Date signed 6/4/45 M.D.

VS 150

G29479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. G29479

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hardwood & Druid Sts.

(c) Hospital or institution: Univ. Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 406 E. 20th St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Patricia Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh.	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/45

8. AGE: Years	Months	Days	If less than one day
	4	1	hr. min.

9. Birthplace Baltimore, (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Brown

13. Birthplace Baltimore

MOTHER 14. Maiden Name Josephine Rotherberger

15. Birthplace Baltimore

16 (a) Informant Wilson Brown

(b) Address 406 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) June 6/4

(c) Cemetery or crematory Holy Cross R.R. Co.

Location

18 (a) Funeral director Geo M. Fink & Son

(b) Address 811 Pulaski St

19 JUN 5 - 1945 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1945, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1945 to 6/4 1945, and that I last saw h.e.r. alive on 6/4 1945.

	Duration
Immediate cause of death Enemia	
Due to Dysentery	
Due to Unresolved pneumonia	4 wks
Other Conditions Hypertrophic adenoids & tonsils	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Otto F. Ewing, M.D. M. D.

Address Un. Hosp. - Balto, Md. Date signed 6/4/45

G29480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G29480 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3125 Leeds Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give
(d) Street No. 3125 Leeds Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline D. Matthews.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John Matthews.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1865

8. AGE: Years 80 | Months - | Days - | If less than one day hr. min.

9. Birthplace Howard County Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Moses Carr.
13. Birthplace Howard Co. Md.,

MOTHER
14. Maiden Name Matilda Green.
15. Birthplace Howard County, Md.,

16 (a) Informant Matilda Black
(b) Address 3125 Leeds St.

17 (a) Burial (b) Date thereof June 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) JUN 5 - 1945
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1945, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCaldin
Medical Examiner.
Date signed 6/1/45

G29481 AB-89313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G29481 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos-28days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Laura Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5-1918

8. AGE: Years 26 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rev. Allen (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Erite ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) JUN 5 - 1945 (month, day, year registered) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3- 1945, at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8- 1944 to 6-3- 1945, and that I last saw her alive on 6-3- 1945.

Immediate cause of death: Pulmonary tuberculosis — Duration: 1 yr

Due to

Due to

Other Conditions Tbc. peritonitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmation

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.
Address Balto City Hosp Date signed 6/4/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

G29482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 d

Registered No. G29482

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 N. Oldham St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Oldham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Paraskevas

3 (b) If veteran, name war: No.
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Milton Paraskevas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1900

8. AGE: Years 45 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Turkey (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Arthur Milona
13. Birthplace Turkey

MOTHER
14. Maiden Name Anna
15. Birthplace Turkey

16 (a) Informant Milton Paraskevas
(b) Address 502 N. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Evangelismos
Location Baltimore, Md.

18 (a) Funeral director Durward D. Covington
(b) Address 24 W. 25th St.

19 (b) JUN 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1945 to 6-2 1945
and that I last saw her alive on 6-1 1945

Immediate cause of death: Carcinoma - cervix uteri — Duration: About 3 yrs

Due to

Due to

Other Conditions: Metastases to pelvic organs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Gonatos M. D.
Address 101 N. Read St. Date signed 6-2-45

X

G29483

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93E

G29483

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Baltimore, 1917 Herbert St
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 1 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1917 Herbert St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME
John Eugene Doeffner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Caroline Doeffner
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1872

8. AGE: Years	Months	Days	If less than one day
72	5 6	7	..... hrs. ..... min.

9. Birthplace Alsace Lorraine, France
(Town, county, and state)
10. Usual occupation Textile worker
11. Industry or business C.R. Daniels (canvas)
FATHER 12. Name Adolphe Doeffner
13. Birthplace France
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Harvey Merton Quimby
Address 1917 Herbert St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)
Cemetery or crematory St. Mary's Cem.
Location Elkton, Md.
18. Funeral director Easton Sons
Address Ellicott City, Md.
19. (Date received) JUN 5 1945 Huntington Williams M.D. Registrar
Approved: John R Davis MD per Robert Le Gratiet M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1945 at 11:20 P M
21) I CERTIFY that death occurred on the date above stated: that I attended deceased from I did not see this man alive. 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion (Born history)	
Due to	
Due to	
Other conditions Myocarditis, Bronchitis (Indicate whether significantly within 3 months of death)	

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Louis T. Levy M. D. or Coroner
Address 1544 W North Ave Date signed 6/5/45

G29484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G29484 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymond Ave + Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6da
(e) Length of stay in Baltimore (yrs., mos., or days) 42yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Herman Av. #15 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Ben Miller
(b) Address 2702 Herman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-45 (month) (day) (year)
(c) Cemetery or crematory Werneman Circle
Location Helwer Pat. Carmel

18 (a) Funeral director Jack Heuer Inc
(b) Address 1739 E. Balto. St

19 (a) (Date rec'd by registrar) JUN 5 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4/1945, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29/1945 to 6/4/1945 and that I last saw her alive on 6/4/1945.

Immediate cause of death a. monitoni

Due to Generalized abdominal carcinomatosis

Due to Primary ca gallbladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/1/45

Major findings of operation: Ca of liver, gall bladder, stomach, omentum, pancreas, & lymph glands.

If autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Benner M.D.
Address W.B.G.H. Date signed M. 6 D. 4/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13D

629485 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Month

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 N Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bessie Goldberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Romania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Solomon Brodsky
13. Birthplace Romania

MOTHER
14. Maiden Name not known
15. Birthplace Romania

16 (a) Informant Miller Miller
(b) Address 1906 N. Payson St

17 (a) Cremate (Burial, cremation, or removal) (b) Date thereof 6-5-45 (month) (day) (year)
(c) Cemetery or crematory DE HIRSH CEMETARY
Location STATIN ISLAND, N.Y

18 (a) Funeral director JACK LEWIS, INC
(b) Address 1439 E BALTO St

19 (a) (Date rec'd by registrar) (b) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4 1945 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to June 4 1945 and that I last saw h alive on June 4 1945.

Immediate cause of death: Cerebral Hemorrhage Duration 2 hrs.

Due to: Chronic Nephritis Duration unknown
Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Ashman M.D.
Address 1921 Eutaw Ave (Date signed 6/5/45)

VS 150

G23486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellemont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Deena Sody

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel
15. Birthplace Russia

16 (a) Informant Samuel Sody
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy & Hamilton St

18 (a) Funeral director Jack Levin Levin
(b) Address 1439 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 4 1945, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to June 4th 1945
and that I last saw h[illegible] alive on June 4 1945.

Immediate cause of death: Pulmonary Oedema
Coronary Thrombosis — Duration: 2 days
Due to: Chronic Cardio-Vascular Disease — 3 days
Due to: — 6 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael A Evans M. D.
Address 2360 Eutaw Place Date signed June 5-45

Huntington Williams, M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29167 ✓ G29167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 E. Balt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 E. Balt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA SHUGAR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife SOLOMON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NATHAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant SAM SHUGAR
(b) Address 5026 QUEENSBURY AVE

17 (a) BURIAL (b) Date thereof 6-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location O'DONNEL ST

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) JUN 5 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5-45 19 at 1.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8th 1945 to June 4th 1945 and that I last saw her alive on June 4th 1945.

Immediate cause of death	Duration
Cardiac Failure	3 days
Due to Cardio Vascular disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Jaukin
Address 100 N. Mulberry Date signed 6/7/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629488 ✓ 629488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94Q Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 OAKLEY AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 OAKLEY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ABRAHAM MERMELSTEIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Sophie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name SCHERR
13. Birthplace RUSSIA

MOTHER
14. Maiden Name RIFKA
15. Birthplace POLAND

16 (a) Informant MRS. ROSE BARON
(b) Address 3013 OAKLEY AVE

17 (a) BURIAL (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HEBREW YOUNG MEN
Location WINDSOR HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) JUN 5 - 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5-45 19 45 at 4: A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1945 to 6/4 1945, and that I last saw h[illegible] alive on 6/4 1945.

Immediate cause of death Coronary Thrombosis — Duration 6 week
Due to Arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum
Address 106 E. Preston Date signed 6/5/45

VS 150

M. D. R. 1208-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29489

CERTIFICATE OF DEATH

1,31a G29489

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 W. Fairmount St. Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 79 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Mary E. Scott

(a) Residence: No. 1521 Fairmount Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Scott

6. DATE OF BIRTH (month, day, year) April 23 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	1	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) May 5, 1944

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md Maryland

FATHER

13. NAME Samuel E. Price

14. BIRTHPLACE (city or town) (State or country) Hagerstown Maryland

MOTHER

15. MAIDEN NAME Harriet ?

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Lucille Tucker

(Address) 1521 Fairmount Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Zion Date 6 June 1945

19. UNDERTAKER Mrs Katie E. Williams

(Address) 322 N. Schroeder St

20. June 5 1945 Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 1, 1945

22. I HEREBY CERTIFY, That I attended deceased from November 8, 1944 to June 1, 1945

I last saw h. alive on June 1, 1945 Death is said to have occurred on the date stated above, at 7 P. M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carotid vascular renal disease	June 1944

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Physical signs & symptoms Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) John E. J. Campbell M. D.

(Address) 639 N. Carey St., Balto., Md.

Dr. Lanyer

G29430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G294-0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5010 Catalpa Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Catalpa Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Lockard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bertie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-1894

8. AGE: Years	Months	Days	If less than one day
51	2	22	hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name James A. Lockard
13. Birthplace Md

MOTHER
14. Maiden Name Mary C. Hoff.
15. Birthplace Md

16 (a) Informant Mrs Bertie V. Lockard
(b) Address 5010 Catalpa Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Baltimore

18 (a) Funeral director A. J. Kuch
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 300 JUN 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 4 15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1945 to May 2 1945 and that I last saw h. liv alive on June 2 1945.

Immediate cause of death Acute Coronary Occlusion — Duration 1 day
Due to Coronary Heart Disease — Duration unknown
Due to Generalized arteriosclerosis — Duration unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 6/4/45

X

629491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

629491

Registered No. 13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Woodyear St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Abraham Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4/23/1900

8. AGE: Years 40 | Months 1 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Hazel Stewart
(b) Address 1100 Woodyear St

17 (a) Burial (b) Date thereof 6/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pusalman

19 (a) JUN 5 - 1945 (b)
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1945, at ..... M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis with
Due to Cavities.
.....
Other Conditions .....
.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard A. Mallett M.D.
Medical Examiner.
Date signed June 9, 1945.

G29493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 9[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 1619 Gilmor St
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence McClain

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: C
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rhoda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1897

8. AGE: Years 48 | Months 2 | Days 9 | If less than one day ____hr. ____min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph McClain
13. Birthplace N. C.

MOTHER
14. Maiden Name —
15. Birthplace N. C.

16 (a) Informant Rhoda McClain
(b) Address 1619 N. Gilmor St

17 (a) Burial (b) Date thereof 6/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Nat
Location Md

18 (a) Funeral director Geo. L. Kelson
(b) Address 1303 Pressatman St

19 (a) JUN 5 1945 (b) Huntington Maryland
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1945, at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulinski M.D.
Medical Examiner.
Date signed 6/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G29493

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29493

Social Sec. # 220 24-5796.

CERTIFICATE OF DEATH ✓ 93

Registered No. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2908 Brantley Road St., 6 Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME John Milton Willingham — If U. S. Veteran specify WAR ...

(a) Residence: No. 2908 Brantley Road St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race.	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of nee Sheely. Gertie M. Willingham.

6. DATE OF BIRTH (month, day, year) Aug. 2 1869

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	9	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Electric Pump Operator.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. City of Balto.

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Martinsburg W. Va.

FATHER

13. NAME Geo. Willingham

14. BIRTHPLACE (city or town) (State or country) Martinsburg W. Va.

MOTHER

15. MAIDEN NAME Margaret Brown

16. BIRTHPLACE (city or town) (State or country) Hunterstown, ...

17. INFORMANT Mrs. Gertie M. Willingham

(Address) 2908 Brantley Road.

18. BURIAL, CREMATION, OR REMOVAL

Place Meadow Ridge Date 6-5 1945

19. UNDERTAKER Loring Byers

(Address) 5005 Park Heights Ave.

20. FILED ..... 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 2 1945 10:30 P M

22. I HEREBY CERTIFY, That I attended deceased from May 1 1945 to June 2 1945

I last saw him alive on June 2 1945 Death is said to have occurred on the date stated above, at 11:P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis	1 Mo
Arteriosclerosis	—

Other contributory causes of importance: Prostatitis —

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19...

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

— If so, specify —

(Signed) Charles J. Mell M. D.

(Address) 5276 Park Hgts Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V.S.

JUN 5 - 1945 Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 107

629494 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co.
(c) City or town Woodlawn.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5436 Dogwood Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Smith.

3 (b) If veteran, name war: None.

3 (c) Social Security Account No. 212-22-5543

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 1887

8. AGE: Years 58 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Packer.

11. Industry or business American Stores Co.

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Pearl A. Williams.
(b) Address 5436 Dogwood Rd.

17 (a) Burial. - Woodlawn - Md.
(Burial, cremation, or removal) (b) Date thereof (month) (day) 45.

(c) Cemetery or crematory Western Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

JUN 5 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 9:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1945 to 6/4 1945 and that I last saw him alive on 6/3 1945

Immediate cause of death: Bronchopneumonia — Duration

Due to: General debility

Due to:

Other Conditions: Insufficient information
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Gladstein

Address Univ. Hosp. Date signed 6/4/45 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G29495

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Colmyer Neurological Hosp

(b) Street address Mercy Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1112 Brentwood Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** James O Egan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name John J Egan

13. Birthplace Ireland

MOTHER

14. Maiden Name Anastasia B Conroy

15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Christ

(b) Address 2750 Pelham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6.6.1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery

Location

18 (a) Funeral director Mary M Wiedefeld

(b) Address 501 E. 32nd St

19 (a) (Date filed by registrar) (b) Huntington Williams Registrar

5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1945, to June 3 1945, and that I last saw h alive on June 3 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardio-vascular renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. F. Cook M.D.

Address Mercy Hosp Date signed 6/5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29496 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N.Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N.Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Vintner

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James Vintner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24/69 ✓

8. AGE: Years	Months	Days	If less than one day
78	0	9	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Mudra
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary ---
15. Birthplace Bohemia

16 (a) Informant Mrs.Rose Soul
(b) Address 702 N.Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto.Md
18 (a) Funeral director Phillips Memorial Home
(b) Address 2024 Orleans St.
19 (a) (Date rec'd by registrar) (b) Williamsport Md

VS 150 JUN 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to June 3 1945, and that I last saw h[illegible] alive on June 3 1945.

Immediate cause of death Diabetic Coma — Duration May 31 45
Due to Diabetes Mellitus — 5/1/44
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rypacek M.D.
Address 801 41 Kenwood Ave signed 6/5/45

X

GARVEY
G29497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1108

G29497
Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 S. Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles L. Garvey GARVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pearl Landebach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15th 1884

8. AGE: Years	Months	Days	If less than one day
61	3	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Candy Maker
11. Industry or business Retired

FATHER
12. Name John J. Garvey
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie T Dougherty
15. Birthplace Baltimore

16 (a) Informant Mr Joseph Garvey
(b) Address 154 Northwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Ave

18 (a) Funeral director John F Henry Inc 6.F.Lees
(b) Address 615 Light St

19 (a) Williams, M.D. (b) JUN 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4/45 19 , at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 6/4 1945, and that I last saw h / m alive on 6/3 1945.

Immediate cause of death Acute Lobar Pneumonia — Duration 7 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Frankel M.D.
Address 1111 Eutaw Pl Date signed 6/4/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G29498 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 745 Dolphin Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA FISHER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	1	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Elijah Levels
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mr. Thomas Johnson
(b) Address 1021 W. Lanvale St.

17 (a) Burial (b) Date thereof 6-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle Street

19 (a) (b) Washington Williams
(Date rec'd by registrar) (Registrar)

JUN 5 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2-45 19 at 10 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 6/2 1945
and that I last saw h[illegible] alive on 6/2 19 45

Immediate cause of death

	Duration
Due to R[illegible] Lobar Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1131 Harlem Date signed 6/3/45

G29499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G29499

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address, 912 W. Lombard St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 W Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine F Leacy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 19 1898

8. AGE: Years 47 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name John Leacy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Doyle
15. Birthplace Ireland

16 (a) Informant Mr John Leacy
(b) Address 912 W. Lombard St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/6/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J Conway Son
(b) Address 401-03 Hollins St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 188 JUN 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1945, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 6-2 1945
and that I last saw her alive on 6-2 1945

Immediate cause of death Hypertension
Vascular disease — Duration 7 years

Due to Chronic Nephritis — 10 years

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature J. Nelson Carey M. D.
Address 10 E Lexington St Baltimore Md Date signed 6-4-45

X

G29:60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G29:00 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 507 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reuling, Elmer J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Genevieve

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Apr 24, 1904

8. AGE: Years	Months	Days	If less than one day
41	1	11 10	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Repair man

11. Industry or business

FATHER
12. Name Rudolph F. Reuling
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mamie L. O'Dea
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mamie G. Reuling
(b) Address 507 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan Inc
(b) Address 901-03 Fallsway

19 (a) 6-5-1945 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1945 to 6-4-1945, and that I last saw h[illegible] alive on 6-4-1945.

Immediate cause of death Cardiac failure
Esophageal varices
Due to E Gastric hemorrhage 6 hrs
Due to –
Other Conditions –
(Include pregnancy within 3 months of death)

Duration
F yrs

Date of operation –
Major findings of operation: –
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry L. Sloan M. D.
Address [illegible] Date signed 6-7-45

G29501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29501 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2440 North Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT L. ENGLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Leota Porter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1883

8. AGE: Years 62 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Eckhart, Md.
(Town, county, and state)

10. Usual Occupation Grocery Store

11. Industry or business

FATHER
12. Name George Engle
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Rephann
15. Birthplace Md.

16 (a) Informant Mrs. Leota C. Engle
(b) Address 2440 N. Charles St.

17 (a) Burial (b) Date thereof 6/6/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frid. Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1909 Eutaw Place
Huntington Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 45 19, at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 6/4/45

G29502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 824 Rutland ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town 824 Rutland Ave
(If outside city or town limits, write RURAL and give town)

(d) Street No. ..... (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) **FULL NAME** Albert Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/19/75

8. AGE: Years 70 | Months - | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Geo. J. Matthews Sr

13. Birthplace Md

MOTHER 14. Maiden Name Elmera ?

15. Birthplace Md

16 (a) Informant Jessie Matthews

(b) Address 824 Rutland Ave

17 (a) Burial (b) Date thereof 6/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Balto. Co. Md.

18 (a) Funeral director Arthur Williams

(b) Address 1515 McElderry

19 (a) 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945; at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to June 2 1945; and that I last saw h[im] alive on June 1 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension with arterio - Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature M. A. Jacobs M.D.

Address 617 North Rd Date signed 6/5/45

JUN 8 1945

VS 150

G29503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Pennington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Savko

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Susie Savko

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28th 1891

8. AGE: Years	Months	Days	If less than one day
53	8	4	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Miner

11. Industry or business Coal

FATHER
12. Name (Unknown) Savko
13. Birthplace Czecho-Slovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary Woomer
(b) Address 1026 Bristol Place Baltimore Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Loudon Park Cold Spring Lane

18 (a) Funeral director Wilson Coffin
(b) Address 1217 N. Paul St.

19 (a) JUN 5 - 1945 (Date rec'd by Registrar) (b) Huntington Wilson Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1945 at 10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/2/45 at 10:30 P. M.
(b) Where did injury occur? HANOVER ST. 2000 feet South of Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by truck

23. Signature Howard A. Mueller M.D. Medical Examiner.
Date signed June 3, 1945

VS 151

20 E. Preston St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G2950 1 61 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
1708 Eutaw Place (Nursing Home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. James Apartments
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET SWAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1871

8. AGE: Years 74 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business State of Maryland

FATHER
12. Name Edward Swain
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sarah M. Gray
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary Brinkley
(b) Address 115 W. Carey Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Incorporated
(b) Address 1217 St. Paul Street

19 (a) 1945 (Registered by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942, to June 4 1945, and that I last saw h[illegible] alive on June 4 1945.

Immediate cause of death: Myocarditis — Duration: 4 years

Due to: Arteriosclerosis — Duration: years

Due to: — Duration: years

Other Conditions: Diabetes Mellitus — Duration: years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry W. Herman M. D.

Address 20 E. Preston St. Date signed 6/5/45

VS 190

935

G29505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (937)

G29505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton and Wilkens Av

(c) Hospital or institution: St Agnes Hospital No

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 310 S. Augusta Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George H Fulmer SR

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1877

8. AGE: Years 67 68 | Months 9 10 | Days 1 22 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Thermometer Setter

11. Industry or business Baltimore City School

FATHER 12. Name Unknown

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant George H Fulmer SR

(b) Address 59 Edmondson Ave Catonsville Md

17 (a) Burial (b) Date thereof 6 8 45 (month) (day) (year)

(Burial, cremation, or removal)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Mitchell & Lockwood

(b) Address 1217 E Fayette St

19 (a) Date rec'd by registrar (b) Harrington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1945 at 6.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1945 to 6/5 1945 and that I last saw him alive on 6/5 1945

Immediate cause of death: cerebral accident — Duration

Due to: arteriosclerotic C-V disease

Due to:

Other Conditions: none known

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard W Steir M. D.

Address St Agnes Hosp. Date signed 6/8/45

X H. W. Steir, M.D.

G29506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312a

G29506 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3307 Alto Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Alto Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth E. Jeffries

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife T. Lucien Jeffries
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1865

8. AGE: Years	Months	Days	If less than one day
79	7	17	hr. min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Ward
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name Sarah Whittington
15. Birthplace Anne Arundel County, Md.

16 (a) Informant Mr. Ward Jeffries
(b) Address 3307 Alto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wells & Corkran
(b) Address 4510 Liberty Heights Ave.

19 (a) 5-1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 45, at 2.10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 19 45 to June 3 19 45, and that I last saw h[illegible] alive on June 2 19 45

Immediate cause of death: Uremia Nephritis — Duration 1 M

Due to: Arteriosclerosis

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. S. Gray M.D.

Address 622 W. North Ave. Date signed 6/5/45

+ Kidney

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Pellens

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29507 Registered No. G29507

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 Cokesbury Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cokesbury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick F. Pellens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
87	-	-	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER 12. Name Frederick Pellens
13. Birthplace Germany

MOTHER 14. Maiden Name Mekenbrun
15. Birthplace

16 (a) Informant F. Pellens
(b) Address 619 Cokesbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 7 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E. 32nd St

19 (a) (b)

Date rec'd by registrar JUN 8 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/1945, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1945, to 6/7 1945, and that I last saw him alive on 6/7 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	4 hrs
Due to Arteriosclerosis	6 mos
Due to Hypocalcemia	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Marks M. D.
Address 752 E 22nd St Date signed 6/8/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G29508

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Pierce St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Duffy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louise
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? - ? - 85

8. AGE: Years 60 | Months 59 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county and state)
10. Usual Occupation Log shoreman
11. Industry or business

FATHER
12. Name Alfred Duffy
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location ~~Baltimore, Md~~ A.D. E. Baltimore, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bluntley ave

19 (a) Date received by Registrar JUN 6 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945, to June 5 1945 and that I last saw him alive on June 5 1945

	Duration
Immediate cause of death: Genital Debility + Septicemia	
Due to: Pneumonia type III Cured.	3 mo
Due to: Empyema (+ Septicemia of P Strep.	2 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Glen Leymaster M.D.
Address Johns Hopkins Hosp. Date signed 6/6/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G29509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 N. Spring st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 r
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 N. Spring st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosie Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Thomas Mullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Mathews Co., Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Charles Patterson

13. Birthplace Va

MOTHER 14. Maiden Name Pinkey White

15. Birthplace Va

16 (a) Informant Queenie Bell Ward

(b) Address 1836 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1905 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bentley Ave

19 (a) JUN 6 - 1905 (Date rec'd by registrar) (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1905, at 6:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1905 to June 3 1905 and that I last saw h[illegible] alive on June 3 1905.

Immediate cause of death Pulmonary TB — Duration 1 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed June 6 1905

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G29510

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Kuhn
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Herman Kuhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1861

8. AGE: Years	Months	Days	If less than one day
83	8	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James H. Galloway
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Lloyd
15. Birthplace Md.

16 (a) Informant Mrs. Mary Hoffelbert
(b) Address 1108 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location East End of Myrtle Ave.

18 (a) Funeral director Fred. A. Keane & Son
(b) Address 1216 N. Charles St.

(a) JUN 6 - 1945 (b) Registrar Williams Signature
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. **DATE OF DEATH** June 3 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to June 3 1945, and that I last saw h alive on June 3 1945.

Immediate cause of death Cardiac Arrhythmia

Due to Senile Myocarditis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration	
	1 day
	6 mos
	1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1108 Randall St. Date signed 6/5/45

G29511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 ✓

Registered No. G29511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Orleans
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Orleans (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min. 67

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Laura Bacon

(b) Address 1504 Orleans st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 / 5 / 45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Ebron O. Wilson

(b) Address 1000 Brantley ave

19 (a) Date rec'd by local registrar 6 JUN 1945 (b) Registrar Huntington Hill

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 8:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945 to June 2 1945, and that I last saw h[illegible] alive on June 2 1945.

Immediate cause of death	Duration
Acute Myocarditis	1 Day
Due to Cerebral Apoplexy	3 Days
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Will LeRoy Berry M. D.

Address 1420 E. Chase Date signed 6 / 2 / 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 142B

Registered No. G29512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alma Bannister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Stewart Penny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/12

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Anne Arundle Co. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lonnie Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Ethel
15. Birthplace Md.

16 (a) Informant Ethel Thomas
(b) Address 767 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/45 (month) (day) (year)
(c) Cemetery or crematory St. Marks
Location a.a. Co. Md.

18 (a) Funeral director Troy O. Wilson
(b) Address 1000 Bradley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1945, at 3A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage due to extra uterine pregnancy.

Due to (Ovarian in type.)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed June 3, 1945.

VS 151

629513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

629513 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Old Green Spring & Belvedere Ave

(c) Hospital or institution: Levindale 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 72 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2212 Park Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Barney Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Memel, Germany (Town, county, and state)

10. Usual Occupation Pet Protection Office

11. Industry or business

FATHER 12. Name

13. Birthplace Germany

MOTHER 14. Maiden Name

15. Birthplace Germany

16 (a) Informant Mrs. A. J. Rosenthal

(b) Address 2212 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-45 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem.

Location Wash. Blvd.

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1439 E. Baltimore St

19 (a) (b) Huntington Williams M.D. Registrar

Filed by registrar JUN 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944, to 6-6 1945, and that I last saw h alive on 6-6 1945.

Immediate cause of death: Chr. end. vas. disease arteriosclerosis, Hypertension

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Edmund Lewis

Address Levindale Date signed 6/6/45

X

G29:14

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29:14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5436 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Harden Apts. Apt 1207 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Louis Lowe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jessie Mae Pultruston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Phila. Pa (Town, county, and state)

10. Usual Occupation Lawyer & Moving Picture Exp.

11. Industry or business

FATHER 12. Name Joseph Henry Lowe
13. Birthplace Russia

MOTHER 14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Jessie Lowe
(b) Address Temple Harden Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6-45 (month) (day) (year)
(c) Cemetery or crematory Ahavath Achim
Location

18 (a) Funeral director Jack Frenes Inc
(b) Address 1439 E. Balto. St.

19 (a) [illegible] (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 1945, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1943 to June 4th 1945 and that I last saw h[illegible] alive on June 2nd 1945

Immediate cause of death: Pneumonia, Hypostatic

Due to: Chronic Myocarditis with Hypertrophy

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 10 minutes | 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael A. Abrams M. D.
Address 2760 Eutaw Place Date signed June 5-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629515 ✓ 629515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts
(c) Hospital or institution: Union Memorial Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2334 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sarah Chayt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mr. Isaac Chayt

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 68 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Russia

16 (a) Informant: Mrs Lillian Saidman (daughter)
(b) Address: 3810 Woodhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-45 (month) (day) (year)
(c) Cemetery or crematory: MISHKON LOREC
Location: SOUTHERN AVE

18 (a) Funeral director: VOGT LEWIS INC
(b) Address: 1439 E. BALTO ST.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

JUN 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5, 1945, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 30, 1945, to June 5, 1945, and that I last saw her alive on June 5, 1945

Immediate cause of death: Cardio-respiratory failure

Due to: Papillary cystadeno carcinoma of the ovary with metastases to the lungs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: 5/30/45 (Thoracentesis)

Major findings of operation: Carcinoma in subdiaphragmatic metastases from ovary.

of autopsy: Not performed

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Frank Supplee III

Address: Union Memorial Hospital Date signed: 6/5/45 (M. D.)

X

G29516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G29516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 Aliceanna Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2, Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Aliceanna Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perthenia Sams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John W.
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March, 24 1882

8. AGE: Years	Months	Days	If less than one day
63	2	12	hr. min.

9. Birthplace Carl W.Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Pittsenbarger
13. Birthplace W.Va.

MOTHER
14. Maiden Name Alginor Walten
15. Birthplace W.Va.

16 (a) Informant John W.Sams (Husband(
(b) Address Carl W.Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ? (month) (day) (year)
(c) Cemetery or crematory Carl Cemetery
Location Carl West Va.

18 (a) Funeral director George A.Weber
(b) Address 705 South Ann Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 6th 1945, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945, to June 6 1945, and that I last saw h-- alive on June 4 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	about
Due to Cerebral Arteriosclerosis	?
Due to Chronic Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 700 [illegible] Date signed 6/6/45

VS 150

G23517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G23517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 S. Broadway (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME FRANK Nechay

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Angela NECHAY

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 24 1894

8. AGE: Years	Months	Days	If less than one day
50 51	10	11	.....hr. .....min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAVERN KEEPER

11. Industry or business FOR SELF

FATHER
12. Name SORVA NECHAY
13. Birthplace RUSSIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace RUSSIA

16 (a) Informant ANGELA NECHAY (WIFE)
(b) Address 821 S. BROADWAY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russ.
Location Anne Arundel Co.

18 (a) Funeral director Selby & Geiler Sons
(b) Address 403 S. Wolfe Street

19 (a) ..... (b) ..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1945 to 6/4 1945 and that I last saw h(M) alive on 6/4 1945.

Immediate cause of death Marasmus

Due to Carcinomatosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Carcinomatosis

Duration
.....
.....
.....
.....
.....
.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Jerry Schenker, M. D.
Address Sinai Hospital Date signed 6/4/45

VS 150

G 29518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163B

Registered No. G-29518 ~~G-29518~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W'st Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Gwynn Oak Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** (WALTER LEE) John Walter Lee Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-6012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Ellen Lee
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 27, 1891

8. AGE: Years	Months	Days	If less than one day
54	1	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Staff Accountant
11. Industry or business C & P Telephone Co.

FATHER
12. Name John Fletcher Lee
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Virginia Biddle
15. Birthplace Baltimore, Md.

16 (a) Informant Walter Lee Jr.
(b) Address 2700 Gwynnmore Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Avenue

19 (a) June 6-1945 (Date rec'd by registrar) (b) Huntington Williams, M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/45 19 ..., at 3:4 pM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbiturate Poisoning (Seconal)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/7/45 at 1 P.M.
(b) Where did injury occur? Home 2023 Gwynn Oak Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Ingestion of Barbiturate

23. Signature John L. Oliver M.D. Medical Examiner.
Date signed 6/11/45

VS 151

G29515 CLARENE MACKSUL . BALTIMORE CITY HEALTH DEPARTMENT ✓ G29515
CERTIFICATE OF DEATH 14 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 W Biddle St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clarene Macksul
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-24-1926

8. AGE: Years	Months	Days	If less than one day
18	9	8 9	hr. min.

9. Birthplace Cherryville N. C. (Town, county, and state)
10. Usual Occupation Packer - Trust Co
11. Industry or business

FATHER
12. Name Fred Macksul
13. Birthplace N. C.

MOTHER
14. Maiden Name Anna Cauthen
15. Birthplace S. C.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 6-6-45 (month) (day) (year)
(c) Cemetery or crematory Cherryville Cemetery
Location Cherryville N. Carolina
18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave, Huntington, West Virginia
19 (a)..... (b)..... (Date received by registrar) Registrar

JUN 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 8 a M
21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1945 to June 3 1945, and that I last saw her alive on June 3 1945

Immediate cause of death	Duration
Tuberculous meningitis	2 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: Tuberculous meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Albert A. Hatter
Address Johns Hopkins Hosp Date signed 6/8/45 M

X

G29520

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29520

CERTIFICATE OF DEATH 1223

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C Fiesler

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-05-5153

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Hannah S Bodesheim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	2	hr. min.

9. Birthplace New York
(town, county, and state)

10. Usual Occupation Retired Conductor

11. Industry or business Long Island R. R.

FATHER
12. Name Carl Fiesler
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Volke
15. Birthplace Germany

16 (a) Informant Mrs. Hannah Fiesler
(b) Address Parkville Md

17 (a) Burial (b) Date thereof 6/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run Md.

18 (a) Funeral director Harry H Welke
(b) Address 4101 Edmondson Ave.

19 (a) JUN 6 — 1945 (Date received by Registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5 1945, at 2:22 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3 1945, to 6-5 1945, and that I last saw him alive on 6-4 1945

Immediate cause of death	Duration
Intestinal Obstruction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Balto. Gen. Hospital Date signed 6-8-1945

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 629521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2134 N. Fulton Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 N. Fulton Av. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Jane Kemper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife William A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30-1864

8. AGE: Years 81 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. County Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at Home

FATHER
12. Name George A. Wachsheim
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Streig
15. Birthplace Pa.

16 (a) Informant Mrs. Lillian B. Toole
(b) Address 2134 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)
(c) Cemetery or crematory Reformed Ch. Cem.
Location Manchester, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar JUN 6 1945 (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 6:33 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1945 to June 5 1945 and that I last saw her alive on June 5 1945

Immediate cause of death: Cerebral Hemorrage — Duration 6/5/45

Due to: Ac. Myocarditis — 1942

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Brown M. D.

Address 663 W. North Av. Date signed 6/5/45

G29522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29522 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 Holder Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Holden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Patzochke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles Patzochke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1864

8. AGE: Years 81 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Frederick Schomberg
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka Stolte
15. Birthplace Germany

16 (a) Informant Theresa Patzochke
(b) Address 5310 Holden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location City

18 (a) Funeral director Sullivan Funeral Home
(b) Address 2008 Orleans St

19 (a) JUN 6 1945 (Date received by Local Registrar) (b) Huntington Williams M.D. (Registrant)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945 to June 4 1945 and that I last saw Dec alive on June 4 1945.

Immediate cause of death Angina Pectoris — Duration 2 days

Due to Chronic Myocarditis — 1 1/2 yrs

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C H Mengert M. D.

Address 1520 E 33rd Date signed 6/6/45

VS 150

G29523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 Strathmore Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town City of Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Hermosa Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) **FULL NAME** Maria Jane Insley

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William G. Insley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 13 - 1863

8. AGE: Years 81 | Months 5 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace near Cambridge - Maryland
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business " "

FATHER 12. Name Henry Pritchett
13. Birthplace near Cambridge, md.

MOTHER 14. Maiden Name ? ? McNamara (?)
15. Birthplace near Cambridge, md.

16 (a) Informant Mrs. Olive K. Wallace (Daughter)
(b) Address 2600 Hermosa Ave. - City - 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 8 - 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave - Balto., md.

18 (a) Funeral director Jos. Joerdens & Son
(b) Address 1927 Park Ave - City

19 (a) JUN 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1945 at 6 A. M

21. I certify that death occurred on the date above stated; that attended deceased from June 1st 1942 to June 5th 1945 and that I last saw h[illegible] alive on May 5th 1945.

Immediate cause of death: Chronic Myocarditis — Duration: 4 years
Due to ...
Due to ...
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at ... M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury None

23. Signature L. L. Gorsky M.D.
M. D.
Address 5106 Harford Rd Date signed 6/7/45

G29524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G29524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Laymon
(c) Hospital or institution: West Baltimore General Hospital 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3070 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ~~AMMON~~ Ammon F Neiswender

3 (b) If veteran, name war W.W.I

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of ~~husband~~ or wife Anna L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1891

8. AGE: Years 54 | Months 0 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Stone Mason Contractor

11. Industry or business

FATHER 12. Name Elias G. Neiswender

13. Birthplace Pa.

MOTHER 14. Maiden Name Laura Tresler

15. Birthplace Pa.

16 (a) Informant Mrs. Anna L. Neiswender

(b) Address 3070 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) ... 1945 (Date rec'd by registrar) (b) Huntington & Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945, to June 4 1945, and that I last saw h[illegible] alive on June 4 1945.

Immediate cause of death Coronary Thrombosis - acute — Duration

Due to Arteriosclerosis

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Coronary Thrombosis - acute

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address West Baltimore Gen. Hosp. Date signed 6/5/45

VS 150

G29525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1940 Registered No. G29525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address P.G.H.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 4
(e) Length of stay in Baltimore (yrs., mos., or days) all but 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Sheehan adopted

3 (b) If veteran, name war — ? —
3 (c) Social Security Account No. 218-10-6864

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Marie Lucille La Bourgeois
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 1 1893
8. AGE: Years 53 | Months 1 | Days 3 2 | If less than one day ..... hr. ..... min.
9. Birthplace Born in Baltimore, Md (Town, county, and state)
10. Usual Occupation Home Guard 4-21-45
11. Industry or business Bethlehem-Fairfield
FATHER 12. Name ? Could not ascertain
13. Birthplace ? could not ascertain
MOTHER 14. Maiden Name ? could not ascertain
15. Birthplace ? could not ascertain
16 (a) Informant Mrs. Marie L. L. Sheehan (wife)
(b) Address New Orleans La.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.
18 (a) Funeral director Stewart Mortuary
(b) Address 10 S. Washington
19 (a) JUN 6 - 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1945, at 9:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature D. J. Sulaski M.D. Medical Examiner.
Date signed 6/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

G29526
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Arundel Hotel Mt. Royal & Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME William J. Stone

3 (b) If veteran, name war: WW #2
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-25-1899

8. AGE: Years: 57 (50) | Months: Unknown | Days: 10 | If less than one day: hr. min.

9. Birthplace: (Town, county, and state)

10. Usual Occupation: Soldier
11. Industry or business:

FATHER
12. Name: Wm D. Stone
13. Birthplace: Md

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: W. A. Chamberlin Co
(b) Address: Washington, D. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 6-6-45 (month) (day) (year)
(c) Cemetery or crematory: Arlington Nat. Va
Location: Virginia

18 (a) Funeral director: W. A. Chamberlin Co
(b) Address: Washington D C

19 (a) (Date filed by Registrar): JUN 6 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945, to June 5 1945, and that I last saw him alive on June 5 1945.

Immediate cause of death: Peripheral Circulatory failure — Duration:

Due to: Hematuria

Due to: Cirrhosis? - ruptured esophageal varices.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. J. Roper
Address: Date signed: 6/5

VS 150

For C. R. Davis by Howard J. Weaver M.D.

G29527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G29527

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1140 Hanover st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Hanover st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary R. Kloid

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frederick W. Kloid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1874

8. AGE: Years 71 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John La Barre
13. Birthplace Md

MOTHER
14. Maiden Name March
15. Birthplace Md

16 (a) Informant Joseph Kloid
(b) Address 1517 Patapsco

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A Cy Co, 2nd

18 (a) Funeral director A. Howard Erwin
(b) Address 1400 E. Chase St.

19 JUN 6 - 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1945 to June 5 1945, and that I last saw h. alive on June 4 1945.

Immediate cause of death: Myocardial Insufficiency

	Duration
Due to	
Due to	
Other conditions Arteriosclerosis & thrombosis (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schneider M.D.
Address 1372 E. Chase St Date signed 6/6/45

X SCHEURICH

G29528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1643

Registered No. G29528

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Benton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1, Box 110
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HIRAM C. HACKLER
CLARKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 31 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Mississippi
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Merchant Marine

FATHER
12. Name Hiram L. Hackler
13. Birthplace Miss.

MOTHER
14. Maiden Name Marria Hendricks
15. Birthplace Miss.

16 (a) Informant Strickland Funeral Home
(b) Address Yazoo City, Miss.

17 (a) Cremate (b) Date thereof 6-6-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Yazoo City
Location Yazoo City, Miss.

18 (a) Funeral director Wadkins Cook Inc
(b) Address 217 S. E. Fourth St. Huntington Indiana

19 JUN 6 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 1:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-5-45 at 1:30 A. M.
(b) Where did injury occur? Foot of An Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped overboard

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 5 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G29529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G29529 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Rankin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-1819

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	(Mar)

6 (b) Name of husband or wife Anna Mae [redacted] (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 10/20/1889

8. AGE: Years	Months	Days	If less than one day
55	7	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Stallings
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie E. Hack
15. Birthplace Maryland

16 (a) Informant Edna Stallings
(b) Address 2219 Rankin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director F. B. Wisner Sons Co
(b) Address 200 Eutaw Place

19 (a) JUN 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1945, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1945 to 6/2 1945 and that I last saw him alive on 6/2 1945

Immediate cause of death Coronary Occlusion — Duration 4 days

Due to Arteriosclerotic C.V. Disease

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Seen ~~on~~ ante mortem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Sandel M. D.
Address Md. Gen. Hospital Date signed 6/2/45

For F. J. P. Davis, by Howard J. Maddux, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29530 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette-Aylesbire Sts
(c) Hospital or institution Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2715 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Adolph E. Kaiser
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Elizabeth D. Kaiser
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 2nd 1880

8. AGE: Years 65 | Months 2 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business Peoples Life Ins Co

FATHER
12. Name Gustave Tabler
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Simmer
15. Birthplace Germany

16 (a) Informant Elizabeth D. Kaiser
(b) Address 2715 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Md

18 (a) Funeral director F. S. Tyldesley Son
(b) Address 650 W. Baltimore St

19 (a) (Date rec'd by registrar) JUN 6 1945 (b) Registrar's No. 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6/45 19..., at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3/45 19..., to 6/6/45 19..., and that I last saw him alive on 6/6/45 19...

	Duration
Immediate cause of death Congestive heart failure	4 days
Bronchial pneumonia	
Due to Hypertensive Cardio-vasc.	7
Due to disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grayson S. Walmsley M.D.
Address Bon Secours Hosp Date signed 6/4/45

G29531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13B

Registered No. G29531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Cumberland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Cumberland St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Eunice Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	colored	Divorced

6 (b) Name of husband or wife Raymond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1910

8. AGE: Years	Months	Days	If less than one day
35	-	24	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Lewis Travis
13. Birthplace Va

MOTHER
14. Maiden Name Mary Woods
15. Birthplace Va

16 (a) Informant Mary Thomas
(b) Address 618 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1305 Pennsylvania Ave

19 (a) JUN 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1945 to 6/3 1945 and that I last saw her alive on 6/2 1945.

Immediate cause of death	Duration
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations NONE
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Wardlaw Moore M. D.
Address 1231 Harlem Ave Date signed 6/5/45

VS 3

Dr. L. J. Shimanek
3711 Falls Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 629532

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Lakewide Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Lakeside Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Ann Reilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Theodore S. Reilly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Ryan
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Lacey
15. Birthplace Ireland

16 (a) Informant Mrs. Edward Wagner
(b) Address 3108 Northway Drive-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

JUN 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to June 4 1945, and that I last saw h[illegible] alive on June 4 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertensive CVD	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Shimanek M. D.
Address 3711 Falls Rd Date signed 6-7-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47 1037 G29533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

Registered No. G29533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County.....
(c) City or town Falkina
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Getel Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-80

8. AGE: Years	Months	Days	If less than one day
64	5	12	.....hr. .....min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sol. Ridvesky
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Granstein
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8/45 (month) (day) (year)
(c) Cemetery or crematory Roosevelt Cemetery
Location Philadelphia Pa

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) JUN 6 - 1945 (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1945, to June 6 1945, and that I last saw h[illegible] alive on June 6 1945.

Immediate cause of death	Duration
Progressing Debilitation,	
Due to Osteosarcoma - metastasized	? 1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature [signature] M.D.
Address Johns Hopkins Date signed 6/6/45

X

4743564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29534

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sunderwood Sanitarium Nurse Home
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Nettie Bishop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-9-88

8. AGE: Years 57 | Months 4 | Days 28 | If less than one day .....hr. .....min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Nurse Rrm.

11. Industry or business

FATHER
12. Name Robert Young.
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Linda.
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto Md

18 (a) Funeral director Lloyd MacNabb
(b) Address Catonsville Md

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 350 JUN 6 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 6 1945, and that I last saw h[illegible] alive on June 6 1945

Immediate cause of death: Cardiac failure — Duration .....
Due to Arteriosclerotic coronary thrombosis with myocardial infarction. — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Albert A. Kattan M.D.
Address Johns Hopkins Hosp. Date signed 6/6/45

X

G29535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 0a

G29535

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The contact age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address tbr

(c) Hospital or institution Univ. Hosp. (Balto, Md)

(d) Length of stay in hospital or inst. (yrs., mos., or days) 65 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Penna (b) County York

(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)

(d) Street No. Jordan Apts
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jules Ellis Sterner

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1931

8. AGE: Years	Months	Days	If less than one day
13	8	7	hr. min.

9. Birthplace York County Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Robert L Sterner

13. Birthplace York County Pa

MOTHER

14. Maiden Name Blanche Bowman

15. Birthplace York County Pa

16 (a) Informant Blanch Sterner

(b) Address Hanover Pa

17 (a) Removal (b) Date thereof June 2 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Hanover Pa.

18 (a) Funeral director W. A. Feeser

(b) Address Hanover Pa

19 (a) 6-6-1945 (b) Harriet Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1945, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1945, to 6-6 1945 and that I last saw him alive on 6-6 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Increased intra cranial pressure	
Due to Rt. fronto parietal brain abcess	
Other Conditions Extra dural abcess (Rt) osteomyelitis Rt frontal bone	

(Include pregnancy within 3 months of death)

Date of operation 6-6-45

Major findings of operation: Same as above

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature P. C. Marmell III M.D.
M. D.

Address Univ. Hosp. Date signed 6/6/45

8

X

G29536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

G29536

Registered No. 58231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Baltimore 11, Md.

(b) Street address Wyman Park Drive

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mo24da

(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo 24da

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 822 South Broadway
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest, Harvey Jacob

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife Madeline Fry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1897

8. AGE: Years	Months	Days	If less than one day
48		17	hr. min.

9. Birthplace Big Run, Pennsylvania
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Seafaring

FATHER

12. Name Jacob Ernest

13. Birthplace New York, New York

MOTHER

14. Maiden Name Elizabeth Franks

15. Birthplace New York, New York

16 (a) Informant John W. Ernst

(b) Address Vandergrift Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-45 (month) (day) (year)

(c) Cemetery or crematory Hadish Cherkel Cem

Location Wellsburg W Va

18 (a) Funeral director A. Lee Odes

(b) Address 4644 Park Ave

19 (a) Date rec'd by Registrar (b) Clayton Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 9:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1945, to June 5 1945, and that I last saw him alive on June 5 1945.

Immediate cause of death	Duration
Heart failure	Unknown
Myocardial infarction	
Arteriosclerotic coronary thrombosis	
Due to Rheumatic fever, mitral and aortic insufficiency	
Due to Aortic stenosis	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Benjamin F Jones

Address U.S. Marine Hospital Date signed 6/7/45

Baltimore 11, Maryland.

G29537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G29537
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Ring Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Askins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years 14 | Months | Days | If less than one day hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chauncey Askins
13. Birthplace Singleton, Md.

MOTHER
14. Maiden Name Alexia Dorsey
15. Birthplace East New Market, Md.

16 (a) Informant Sarah Askins
(b) Address Cambridge, Md.

17 (a) Burial (b) Date thereof June 8 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Cambridge, Md.

18 (a) Funeral director Lloyd H. Bayne
(b) Address Cambridge, Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

JUN 6 - 1945
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1945, at 6:12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1945, to 6-6 1945, and that I last saw h[illegible] alive on 6-5 1945.

Immediate cause of death Septicemia

	Duration
Due to Pulmonary edema	
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

If autopsy: Cerebral edema, Pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Univ. Hospital Date signed 6-6-45

24a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13A

✓ 629536 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Riley

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-04

8. AGE: Years 40 | Months 8 | Days — | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Assembler

11. Industry or business

FATHER
12. Name Andrew Riley
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Rinker
15. Birthplace Va

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/6/45 (month) (day) (year)
(c) Cemetery or crematory Hyattsville
Location Hyattsville Md.

18 (a) Funeral director Francis Gaseby Sons
(b) Address Hyattsville Md.

JUN 7 - 1945 (b) (Date rec'd by Registrar) Registrar

JUN 7 - 1945 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1945 to June 6 1945 and that I last saw deceased alive on June 6 1945

Immediate cause of death Uremia

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene A. Vance
Address Johns Hopkins Hospital Date 6/6/45

G29539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G29539

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St
(c) Hospital or institution Md. Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Baltimore Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oak St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Whiteley (Lang Currie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace N. Carolina (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Daniel Currie

13. Birthplace N. C.

MOTHER 14. Maiden Name Sizzie Whitted

15. Birthplace NC

16 (a) Informant Mrs Dement

(b) Address Essex Md

17 (a) Shipped (Burial, cremation or removal) (b) Date thereof 6 8 45 (month) (day) (year)

(c) Cemetery or crematory Fayetteville N. C.

Location

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) JUN 7 - 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4-45 1945, at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest and abdomen.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-4-45 at 11:P. M.
(b) Where did injury occur? Md Penitentiary 954 Forrest St.
(c) Did injury occur at home, on farm, industrial place, in public place Md. Pen. While at work? ?
(d) Means of injury Stabbed

23. Signature Homer L. Woodside M.D.
Medical Examiner.

Date signed 6-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please

6295-40

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150 C

Registered No. 6295-40

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 18 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Cator Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hanneloon 25677

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband ~~or wife~~ Herbert A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21st 1914

8. AGE: Years 31 | Months 2 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Washington DC. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William B. Donnelly
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Taylor
15. Birthplace Md.

16 (a) Informant Hubert Hanneloon
(b) Address 823 Cator Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/8/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location Balto, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUN 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1945, at 1:21 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 6 1945, and that I last saw him alive on June 5 1945.

Immediate cause of death	Duration
- Acute Pulmonary Edema	
Due to - Rheumatic Cardio - Vascular Disease	
Due to (Mitral Stenosis & Insufficiency)	
Other Conditions Fifth day Post Partum	over

(Include pregnancy within 3 months of death)

Date of operation - 6/4/45

Major findings of operation: Pomeroy Sterilization

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. N. Froard M. D.
Address University Hosp. Date signed 6/6/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G29541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 748 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 748 W Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George. P. Zebrauskas

3 (b) If veteran, name war 2 | 3 (c) Social Security Account No. 29

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Victoria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Peter

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant George G. Zebrauskas
(b) Address 748 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7-45 (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Rauskas
(b) Address 607 Washington Blvd

19 (a) JUN 7 - 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1945, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1940 to 6-4 1945, and that I last saw h[im] alive on 6/4 1945.

Immediate cause of death Acute Cardiac Failure — Duration 1d.
Due to Cardiovascular Renal — 5yr
Due to Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph R Lauricella
Address 607 Washington Blvd Date signed 6/5/45 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629542 ✓ 629542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant A
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Port

18 (a) Funeral director Charles R Law
(b) Address 802 Madison ave.

19 (a) 6-7-1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 1.20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Phosphorus Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-3-45 at 1.20 P.M.
(b) Where did injury occur? 1208 Madison ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Ingestion of rat poison.

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 6-4-45

G29543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G29543

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 733 N. Eutaw St

(c) Hospital or institution:

11

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 733 N. Eutaw St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elenora Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm Matthews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 58 | Months 9 | Days | If less than one day hr. min.

57

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Smith

13. Birthplace Md

MOTHER 14. Maiden Name Emma

15. Birthplace Md

16 (a) Informant Mrs Mayo

(b) Address 2663 McCulloh St

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)

(c) Cemetery or crematory

Location Arbutus

18 (a) Funeral director Chas H Alexander

(b) Address 1 or 2 nc Calhoun St

19 (a) Filed by registrar Huntington Williams

VP-156

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1945 to 6/3 1945 and that I last saw her alive on 6/1 1945

Immediate cause of death Chronic Myocarditis — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J B Huntington

Address 450 W. Biddle St. Date signed 6/5/45

X

G29544

Grave #8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G29544
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JUN 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 6 1945 Hunting Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gretz M.D.
Medical Examiner.
Date signed May 13 1945

G29545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. G29545

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hos. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey R. Nurse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address
19 JUN - 6 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions Fatty degeneration of liver, Edema of brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D.
Medical Examiner.
Date signed June 1, 1945

1-1746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29546

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 B

Registered No. G29546

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. S. Rolling Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Knapp.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-45

8. AGE: Years	Months	Days	If less than one day
—	—	5	hr. min.

9. Birthplace Balto. 17, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Alfred Marion Knapp.
13. Birthplace Catonsville, Md.

MOTHER
14. Maiden Name Jane McCauley Kirkley Knapp
15. Birthplace Balto., Md.

16 (a) Informant Jane McCauley Kirkley Knapp
(b) Address Balto. Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 5 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 6 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1945, at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1945 to 5-24 1945 and that I last saw her alive on 5-24 1945

Immediate cause of death	Duration
(a) Congenital Craniorachischisis	5 days
Due to	
Due to	
Other Conditions Anencephalus	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Edgar Rucker M. D.
Address Hosp for Women of Md Date signed 5-31-45

2545

G29547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G29547

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address -
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town 876 W. Fayette St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. 1 Md (If rural give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Virgil Rosier Jr.
3 (b) If veteran, name war -
3 (c) Social Security Account No. -
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife -
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/30/45
8. AGE: Years 0 Months 0 Days 0 If less than one day 4 hr. 30 min.
9. Birthplace University Hosp, Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Kenneth Virgil Rosier Sr.
13. Birthplace Parsons, West Virginia

MOTHER
14. Maiden Name Marie Rosier
15. Birthplace Mckeesport, Pennsylvania

16 (a) Informant Marie Rosier
(b) Address Mckeesport, Pennsylvania

17 (a) City Disposal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN - 6 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30/45 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/30 1945 to 5/30 1945 and that I last saw him alive on 5/30 1945

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Rowe M.D. M. D.
Address University Hosp. Date signed 6/5/45

VS 150

47 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G29548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reynor & Dukeland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. # 22 Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 A. Alder Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bowser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace West Balto. Gen. Hosp.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Claire Bowser
13. Birthplace Penna.

MOTHER
14. Maiden Name Roberta Jean Piper
15. Birthplace Penna.

16 (a) Informant Mrs. Roberta Bowser
(b) Address 8 A Alder Drive, Balto. # 22

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 5 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 6 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 12 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945 to June 4 1945, and that I last saw h.im alive on June 4 1945.

Immediate cause of death
Premature birth 1 lb 15 oz

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M.D.
M. D.
Address West Balto Gen Hosp Date signed 6/5/45

VS 150

2744

G29549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29549 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2832 Huntingdon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Huntington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton M. Mann.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-8231

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edna M. Mann

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1876

8. AGE: Years 69 | Months 3 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace York Pa (Town, county, and state)

10. Usual Occupation Retired Brakeman

11. Industry or business Penna R.R.

FATHER
12. Name Franklin G. Mann
13. Birthplace Scotland

MOTHER
14. Maiden Name Susan Braley.
15. Birthplace York, Pa

16 (a) Informant Edna M. Mann.
(b) Address 2832 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 JUN 7 - 1945 (b) Huntington Williams M.D. (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1945, at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to June 4, 1945, and that I last saw him alive on June 4, 1945

Immediate cause of death Coronary Thrombosis — Duration 3½ yrs.
Due to Arteriosclerosis
Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Mann M. D.
Address 2902 Huntington Ave Date signed 6/6/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29550 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Homewood Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nora A. Hanrahan Dinan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John T. Dinan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1863

8. AGE: Years 82 | Months 4 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Hanrahan
13. Birthplace ?

MOTHER
14. Maiden Name Mary Walsh
15. Birthplace ?

16 (a) Informant Miss M. Marie Dinan
(b) Address 1122 Homewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUN 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to 6/5 1945, and that I last saw h[illegible] alive on 6/4 1945.

Immediate cause of death Arteriosclerotic Cardio Vascular Renal Disease — Duration

Due to ...

Due to ...

Other Conditions ...
(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operations: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature Joseph L. Blum M. D.

Address 1206 E. Preston St. Date signed ...

X

G29551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G29551
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2745 Booket Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B. Richard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1911

8. AGE: Years	Months	Days	If less than one day
33 34	7	29	hr. min.

9. Birthplace Prince Edward City, Va.
(Town, county and state)
10. Usual Occupation Sheet Painter
11. Industry or business Bethlehem - Fairfield

FATHER
12. Name Bray Richard
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty Medley
15. Birthplace Virginia

16 (a) Informant Mabel Redd
(b) Address 1816 Ashland Ave.

17 (a) Removal (b) Date thereof 6/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Old New Hill
Location Prince Edward County, Va.

18 (a) Funeral director Joseph B. Cooke, Jr.
(b) Address 1360 N. Central Ave.

19 (a) (b) BY Huntington Williams, M.D.
(Date received by registrar) Registrar

JUN 7 1945

V3-151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound
8 c chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 4 1945 at 12 15 A M.
(b) Where did injury occur? 2745 Booket Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 4 1945

G29538 ✓ G29538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Partee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ernest Partee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Turkey N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Caldwell
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice
15. Birthplace N. C.

16 (a) Informant Ernest Partee
(b) Address 803 N. Bond Street

17 (a) Burial (b) Date thereof June 7, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) (b) Kate R. Williams M.D.
(Date rec'd by registrar) Registrar

VS 181 JUN 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1945, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 6/7/45

G29553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Albert Loveday

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single —

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 3 1929

8. AGE: Years	Months	Days	If less than one day
16	4	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Harry Loveday
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillian Brown
15. Birthplace Balto. Md

16 (a) Informant Mrs. Lillian Jones
(b) Address 1605 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) 6 - 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 1 - 1945, at 12 50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-1-45 at 23/3 6.15 P.M.
(b) Where did injury occur? Spring Garden
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Swimming.

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 6-2-45

VS 151

Thursday for Hillsboro M.T.

G29554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G29554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Pine Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eula Mae Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Femal	Colored	Married

6 (b) Name of husband or wife Jackson Jennings
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1920

8. AGE: Years	Months	Days	If less than one day
24	9	24	hr. min.

9. Birthplace Rock Hill, S.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Dunches
13. Birthplace Lancaster Co S.C.

MOTHER
14. Maiden Name Jiles Washington
15. Birthplace Lancaster Co. S.C.

16 (a) Informant Elizabeth Pate
(b) Address 666 N. Saratoga St

17 (a) Burial (b) Date thereof June 7, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rock Hill
Location South Carolina

18 (a) Funeral director Mrs. Katie R. Wesley
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntingtown Md
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/30/45 at 4:45 P. M.
(b) Where did injury occur? 417 Pine Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Shot

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 31 1945

G29555 HEALTH DEPARTMENT—CITY OF BALTIMORE G29555

CERTIFICATE OF DEATH

48a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Retreat St. St., 13 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

If U. S. Veteran specify WAR .....

2. FULL NAME Alice Anthony 15

(a) Residence: No. 1601 Retreat St. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	colored	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Anthony

6. DATE OF BIRTH (month, day, year) July 22, 1915

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	10	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Ga

FATHER

13. NAME Dave Baker

14. BIRTHPLACE (city or town) (State or country) Ga

MOTHER

15. MAIDEN NAME Ruth Wilbotern

16. BIRTHPLACE (city or town) (State or country) Ga

17. INFORMANT Charles Anthony
(Address) 1601 Retreat St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Auburn Date 6-9-1945

19. UNDERTAKER Geo. L. Kelson
(Address) 1303 Pennsylvania Ave

20. FILED JUN 7 - 1945 .....
Registrar.

Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 6, 1945

22. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1944 to June 6 1945

I last saw her alive on June 4, 1945 Death is said to have occurred on the date stated above, at 4:15 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma Cervix uteri	1943
Other contributory causes of importance: Pulmonic edema	unk

Was an operation performed? no Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? Microscopic Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify .....

(Signed) E. Schlenger M. D.

(Address) 1600 Liberty Hts Ave.

X

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Jenkins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Jenkins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence A. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-7-1904

8. AGE: Years 41 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (City, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name William H. Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Deedon
15. Birthplace Md.

16 (a) Informant Wm. H. Thomas
(b) Address 1025 Jenkins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 JUN 7 - 1945 (Date rec'd by Local Reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1945, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31 1945 to 6-3 1945 and that I last saw h[illegible] alive on 6-3 1945

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Ashmead Jones M. D.
Address 5-5-4 Adolphus Hall Date signed 6-4-45

VS 180

G29557 ✓ G29557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

'42B Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Burgundy St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Koenig

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb. 1909

8. AGE: Years 36 | Months 3 4 | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Hughes
13. Birthplace Balto.

MOTHER
14. Maiden Name Lusia Maskill
15. Birthplace Balto.

16 (a) Informant Barbara Krystofiak
(b) Address 120 N. Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 9 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Mart. H. E. Dugoli's Sons
(b) Address 328 S. Conkling St.

19 (a) JUN 7 - 1945 (Delivered by registrant) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945 to June 6 1945 and that I last saw her alive on June 5 1945.

Immediate cause of death	Duration
Pulmonary Embolism	3 Days
Due to Cerebral Hemorrhage	10 Days
Due to Mitral Regurgitation.	Indef.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M.D.
Address 1600 Monroe St Date signed 6/7/45

VS 190

G29558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

G29558 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Hodge HODGE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Norman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1893

8. AGE: Years 51 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Atlanta Georgia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Bennett
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Relative.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location U. A. County Md

18 (a) Funeral director McRoberts & Elliott
(b) Address 4 [illegible] Caroline St

19 (a) JUN (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945; at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 19[illegible] to June 5 19[illegible] and that I last saw h[illegible] alive on June 5 1945.

Immediate cause of death carcinoma breast

Due to ? Dissecting aneurysm. ? Coronary occlusion.

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy dissecting aneurysm

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Graham C. Amos

Address Johns Hopkins Hosp. Date signed 6/9/45

VS 150

G29559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1942

G29559 Registered No.

PLEASE WRITE PLAINLY. ... item of information should be carefully supplied. The correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 Bergen St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Newkirk, Jr.

3 (b) If veteran, name war None.

3 (c) Social Security Account No. 239-12-4688

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 39 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Benjamin Newkirk, Sr.
13. Birthplace N. C.

MOTHER 14. Maiden Name Emma Harring
15. Birthplace N. C.

16 (a) Informant Richard Newkirk
(b) Address 514 Eisleim Street

17 (a) ... (Burial, cremation, or removal) (b) Date thereof 6-7-45 (month) (day) (year)
(c) Cemetery or crematory W. L. Cemetery
Location Baltimore Md.

18 (a) Funeral director Walter B. Springs
(b) Address 1823 Hamilton St.

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1945, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sullivan M.D. Medical Examiner.
Date signed 6/3/45

G29560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29560 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 N. Patterson Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Patterson Pk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN ALIEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 19, 1889
8. AGE: Years 55 Months 11 Days 17 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wall
15. Birthplace Baltimore, Maryland

16 (a) Informant Deal George Allen - son
(b) Address 1312 Kenhill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE? & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH June 5, 1945, at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-1939, to 6-5-1945, and that I last saw h[illegible] alive on 6-4-1945.

Immediate cause of death: Hypertensive cardiac disease — Duration: Uncertain

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred B. Sybert M. D.
Address 1307 Harford Av. Date signed 6-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 83a

G29561
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 639 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 Dolphin St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peggy Michael

3 (b) If veteran, name war — 3 (c) Social Security Account

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1885

8. AGE: Years 60 | Months 4 | Days 17 | If less than one day min. 19

9. Birthplace Bishop S C
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Manson Lampson
13. Birthplace S C

MOTHER
14. Maiden Name Irene Henry
15. Birthplace S C

16 (a) Informant Manson Michael
(b) Address 5813 Kibler St

17 (a) Burial (b) Date thereof June 7, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore County Md

18 (a) Funeral director Chas. H. Logue
(b) Address 512 Carroll Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

JUN 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1945 to 6-3 1945 and that I last saw h alive on 6-3 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	2 Days
Due to Cortema Selerosis	Apl 1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 554 Dolphin St Date signed 6-3-45

G29502 G29502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Elsinor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Elsinore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. LATCH, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline Hall Latch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1877

8. AGE: Years	Months	Days	If less than one day
68	2	9	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Retired Auditor
11. Industry or business

FATHER
12. Name Gardner C. Latch
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Mary A. Beamish
15. Birthplace Phila., Pa.

16 (a) Informant Mr. William J. Latch, Jr.
(b) Address 4115 Bellvieu Ave. 15

17 (a) Burial (b) Date thereof 6/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 7 - 1945 Interington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1945, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to June 5 1945, and that I last saw h im alive on June 4 1945.

Immediate cause of death	Duration
Myocarditis about	2 mo.
Due to Advanced Arterio-sclerosis & hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stella S. Riblett M. D.
Address 2220 Garrison Blvd Date signed 6/3/45

VS 150

G29563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G29563 Registered No. (na)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 N. Rosedale St.
(c) Hospital or institution:

16 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 N. Rosedale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT E. SORRELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ada Sorrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1880

8. AGE: Years	Months	Days	If less than one day
64	5	15	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Balto. Salvage Co.

FATHER
12. Name Thomas Sorrell
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Vernon T. Sorrell
(b) Address 2706 Taylor Ave. 13

17 (a) Burial (b) Date thereof 6/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1945, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1945 to June 6 1945, and that I last saw h— alive on June 1 1945.

Immediate cause of death	Duration
Malignant Hypertension	
Due to Arteriosclerosis	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ←
Major findings of operation: ←
of autopsy: ←

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ←
(b) Date of occurrence ← at ← M
(c) Where did injury occur? ←
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Durand S. French M. D.
Address 2379 Orems Rd. Date signed 6/7/45

VS 150

ac. X

G29564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G29564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Brohawn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Brohawn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Milton Conway

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1851

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillie M. Conway
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) October 13, 1883

8. AGE: Years	Months	Days	If less than one day
61	7	23	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Armous & Co.

FATHER
12. Name Mr. Conway
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace U.S.

16 (a) Informant Mrs. Lillie M. Conway
(b) Address 2408 Brohawn Ave.

17 (a) Burial (b) Date thereof June 9th, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) (Interred by Registrar) (b) Huntington Wilkins Registrar

JUN vs 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 11.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to June 6 1945.
and that I last saw him alive on June 5 1945.

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Cancer of pancreas and Gallbladder — 9 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R O Adams M. D.
Address 2708 Hollins Ferry Rd Date signed 6/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94R

G29565
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Anthony Bentz

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 216-05-3597

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Sara R. Bentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1889

8. AGE: Years	Months	Days	If less than one day
55	7	12	hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual Occupation: Manager
11. Industry or business: Curtis Equipment Co

FATHER
12. Name: William Bentz
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Margaret Cavanaugh
15. Birthplace: Baltimore Md

16 (a) Informant: Sara R. Bentz
(b) Address: 3800 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9 1945 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md

18 (a) Funeral director: Harry J. Armacost
(b) Address: 4204 Ridgewood Ave

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 6 1945, and that I last saw h[illegible] alive on June 6 1945.

Immediate cause of death: Angina Pectoris — Duration 6/7/44
Due to: Dilated heart
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Hugh D. Bedell M. D.
Address: 606 Park Heights Ave Date signed 6/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G29566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Stiles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Stiles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Josephine Branciforte

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Marcello Branciforte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1888

8. AGE: Years	Months	Days	If less than one day
57	2		hr. min.

9. Birthplace Valguarnera Caropepe Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Angelo Contrino
13. Birthplace Italy

MOTHER
14. Maiden Name Lucia Toscano
15. Birthplace Italy

16 (a) Informant Rose M. Penna (Daughter)
(b) Address 400 S. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) Filed JUN 7 - 1945 (b) Registered by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 4 1945, and that I last saw h M alive on June 4 1945

Immediate cause of death: Cardiac Failure — Duration, 36 min.

Due to: Bronchial Asthma & Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Med-Lets Bldg Date signed June [illegible]

G29567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29567 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 W. Randall
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 W. Randall (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Sarah D. McKeldin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George E. McKeldin
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 5, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	1	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Joseph Nash
13. Birthplace Balto Md

MOTHER
14. Maiden Name Laura (?)
15. Birthplace Balto Md

16 (a) Informant Joseph L. McKeldin - (Son)
(b) Address 122 W. Randall

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof June 9, 1945 (month) (day) (year)
(c) Cemetery or cremator Mt. Olivet Cem.
Location Balto Md

18 (a) Funeral director A. Leopold Brous
(b) Address 1400 E. Chase St

19 (a) Huntington Williams M.D. (Date received by registrar) (Registrar)

JUN 7 - 1945

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1945, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to June 6 1945, and that I last saw her alive on June 6 1945.

Immediate cause of death	Duration
Exhaustion	3 days
Due to Cerebral Hemorrhage.	2 wks.
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. H. Campbell
Address 1611 Hanover St Date signed 6/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629568

Duia

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 629568

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 - Biddison Lane
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Carol Ann Dula

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3rd 1944

8. AGE: Years | Months 8 | Days 4 | If less than one day .....hr. .....min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name Albert Dula
13. Birthplace Pa.

MOTHER 14. Maiden Name Ann Avdosky
15. Birthplace Pa.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 9 45 (month) (day) (year)
(c) Cemetery or crematory Pringle Hill Cem
Location Kingston Pa.

18 (a) Funeral director Bagalow Funeral Home
(b) Address 7401 Belair Rd

19 (a) (Name of Registrar) (b) Huntington Williams, M.D.

JUN 7 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31-1945 to 19..., and that I last saw h.. alive on 6-7 1945

Immediate cause of death	Duration
Congenital Heart Disease	8 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Tetralogy of Falot

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Huntington Williams M. D.

Address 1 E Pk Date signed 6-7-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G29569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1129 Valley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Radford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna Radford.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1860

8. AGE: Years 84 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business Waste & Junk.

FATHER
12. Name John Radford.
13. Birthplace Ireland.

MOTHER
14. Maiden Name ~~O'Donnell~~ HARTWELL
15. Birthplace Ireland

16 (a) Informant John L. Radford.
(b) Address 1129 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral.
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights
Huntington Williams Mort. (Date received by registrar) Registrar

JUN 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h.im. alive on June 3 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	2 Weeks
Due to Myocarditis	6 mos
Due to Senile Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Wirth M.D.

Address 502 E 22nd St. Date signed 6/6/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29570 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Lancaster Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Lancaster Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Bochniak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Karolina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Copper Works

FATHER
12. Name Thomas Bochniak
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna ?
15. Birthplace Poland

16 (a) Informant Mrs. Karolina Bochniak
(b) Address 1530 Lancaster Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 9--45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) JUN 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1945; at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to June 6 1945, and that I last saw him alive on June 6 1945.

	Duration
Immediate cause of death CORONARY OCCLUSION	6/6/45
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	??
Due to	
Other Conditions 1- BILATERAL INGUINAL HERNIA 2- PROSTATIC HYPERTROPH (Include pregnancy within 3 months of death)	

Date of operation NONE

Major findings of operation:

of autopsy: NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Drenga

Address 209 Chester St. Date signed 6/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

G29571

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline + Hoffman Sts.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 534 N. Pulaski St. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Thomas B. Fonte

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-10-4988

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Anna E. Fonte

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 12/25/93

8. AGE: 51 Years | Months 5 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto. Transit Co.

FATHER

12. Name Frank Fonte

13. Birthplace Italy

MOTHER

14. Maiden Name Rosario Fonte

15. Birthplace Italy

16 (a) Informant Mrs. Anna E. Fonte

(b) Address 534 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8 / 45 (month) (day) (year)

(c) Cemetery or crematory Mem. Cathedral

Location Old Frederick Rd.

18 (a) Funeral director Fred A. Krause & Sons

(b) Address 1216 N. Charles St.

19 (a) ____ (b) ____ Registrar

(Date of City registry)

JUN 7 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1945 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/ 1945 to 6/5/ 1945, and that I last saw him alive on 6/5/45 19 .

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to Cachexia

Due to Hypernephroma with extensive metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edmund Scanlon

Address St. Joseph's Hosp. Date signed 6/8/45

G29572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945

G29572 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EPPS

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 12, 1898
8. AGE: Years 46 | Months 9 | Days 22 | If less than one day hr. min.
9. Birthplace Blackstone, Va. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Frank Fitzgerald
13. Birthplace Va.

MOTHER
14. Maiden Name Mary B. Epps
15. Birthplace Blackstone, Va.

16 (a) Informant Mr. B. T. Morgan
(b) Address 1923 Penna Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.
18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.
19 (a) (Date rec'd by registrar) JUN 7 - 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH June 4, 1945 at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 6/4 1945
and that I last saw h[illegible] alive on 6/4 1945

Immediate cause of death: Hypertensive Type Heart Disease — Duration
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan R. Eickes
Address 601 N. Calhoun St. Date signed 6/6/45 (M) (D)

X

G29573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945

G29573
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town San Antonio
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Elizabeth Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Steves Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Annie Steves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21-84

8. AGE: Years	Months	Days	If less than one day
60	8	16	hr. min.

9. Birthplace Texas
(Town, county, and state)
10. Usual Occupation lumber.
11. Industry or business

FATHER
12. Name Albert Steves Sr.
13. Birthplace Texas.

MOTHER
14. Maiden Name Fannie Batty
15. Birthplace Texas.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery ~~crematory~~ Mission Memorial Park
Location San Antonio Texas
18 (a) Funeral director Chas O. Mitchell & Sons
(b) Address 1900 Eutaw Place
19 (a) JUN 7 - 1945 (Date rec'd by registrar) Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-1945, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2-1945 to 6-7-1945, and that I last saw h.. alive on 6-7-1945.

Immediate cause of death: mediastinitis — Duration 7 days
Due to: Morphine and perforation
Due to: chicken bone
Other Conditions: Pleural effusion & pneumonia left lung, pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence 6/2/45 at M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? no
(Specify type of place)
(e) Means of injury Foreign body in esophagus

23. Signature W. H. Mueller, M.D.
Address The Johns Hopkins Hosp. Date signed 6-7-45

Hartung & Wilson, Hospital, Md.
Affirmed by Howard J. Clemens M.D.

G29574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JO #93849

Registered No. G29574

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 516 N. Conway St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1900

8. AGE: Years	Months	Days	If less than one day
44	11	-7-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Lloyd Dorsey (d)

13. Birthplace Maryland

MOTHER

14. Maiden Name Della Robinson

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 7 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 7 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1945, at 5:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26, 1945, to May 31, 1945, and that I last saw h im alive on May 30, 1945.

	Duration
Immediate cause of death Hypertensive cardio-vascular disease	6 mos
Due to renal ischemia & chronic nephritis	
Due to	
Other Conditions Tbc. of lungs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmation

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harold Hilton M.D.

Address Balto City Hosp Date signed 6/1/45

VS 150

748 131a

G29575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G29575 Registered No.

JO #16815

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1-28days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1568 Ridgely Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28?, 1876

8. AGE: Years	Months	Days	If less than one day
69	-4-	6?	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel J. Wheeler
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elizabeth LeCompt
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 7 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 19 45, at 4:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Carcinomatosis
Ret. undetermined

Duration 7

Due to

Due to

Other Conditions Bronchopneumonia
Renal insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of inj

23. Signature M. D.
Addr Date signed 6-7-45

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29576

JL - 93330

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G29576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hinds Or Joseph Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1900

8. AGE: Years 44 | Months 11 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Gibbs Packing Co.,

FATHER
12. Name John Hines
13. Birthplace N. C.

MOTHER
14. Maiden Name Janie Hines
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 7 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 19 45, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 19 45 to May 31 19 45, and that I last saw him alive on May 31 19 45.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to Pulmonary Tuberculosis	(?)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lois Edwards

Address Baltimore Md. Date signed M. 6/7/45

VS 150

1-49

G29577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G29577.

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2720 E Biddle St
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 E Biddle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-0142

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Laura M Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1869

8. AGE: Years 75 | Months 9 | Days 8 | If less than one day hr. min. 1869

9. Birthplace (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business Sparrows Pt.

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Miss Katherine Hartlove
(b) Address 2720 E Biddle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9/45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore Md

18 (a) Funeral director Wilmot Funeral Home
(b) Address 2058 Orleans St

19 (a) (Date received by registrar) (b) Registrar

JUN 7 1945 Lyton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 2:44 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 6 1945, and that I last saw him alive on June 6 1945.

Immediate cause of death Myocardial failure — Duration

Due to Age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Frank Hartlove

Address 1123 St Paul St Date signed 6/8/45

X

G29578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29578
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5606 Fair Oaks Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 Fair Oaks Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian A. Finke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Egbert A. Finke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1892

8. AGE: Years	Months	Days	If less than one day
57	11	15	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Herman F. Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Anna H. Stigel
15. Birthplace Maryland

16 (a) Informant Mrs. Egbert A. Finke
(b) Address 5606 Fair Oaks Ave.

17 (a) Burial (b) Date thereof 6-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Conrad J. Reuter
(b) Address 5305 Harford Rd

19 (a) 1945 (b)
(Date received by registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1945 to June 5 1945 and that I last saw h[illegible] alive on June 5 1945.

Immediate cause of death	Duration
Acut Cardiac Dilatation	2 days
Due to Hypertens Heart Disease	1 yr
Due to Arterio-Sclerosis	7 yrs.
Other Conditions Diabetes Mellitus Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 1507 E. 33rd Date signed 6/6/45

VS 150

93D

3 JG29579.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

G29579 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Schmeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Hinderman
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Margaret O'Neill
15. Birthplace Baltimore Md

16 (a) Informant Mrs Cecelia Hild
(b) Address 2126 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director George A Farley
(b) Address Fulton + Fayette

19 (a) JUN 7 1945 (Date received by registrar) (b) Registered No.

VS 150

Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 6:60 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1945 to 6/7 1945 and that I last saw h e alive on 6/5 1945

Immediate cause of death Intestinal Obstruction

Due to Post Operation Perforation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas L Carr Jr

Address Date signed 6/6/45 M/D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G29580 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 S Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 S Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Eberling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Catherine F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 13 1850

8. AGE: Years	Months	Days	If less than one day
65	2	23	hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Retired Police Officer

11. Industry or business

FATHER
12. Name John F Eberling
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Shaver
15. Birthplace Maryland

16 (a) Informant Mrs. Catherine Eberling
(b) Address 121 S Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette

19 (a) 9045 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1944, to June 5 1945, and that I last saw him alive on June 5 1945.

Immediate cause of death	Duration
Pulmonary Oedema	
Due to Myocarditis	
Due to Hypertension-Arteriosclerosis	
Other Conditions Carcinoma of Oesophagus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C Nuttall M.D.

Address 2151 Wilkens Ave. Date signed 6-7-45

VS 150

929

G29581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. G29581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4018 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4018 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie E. Benson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Roland L. Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1901

8. AGE: Years	Months	Days	If less than one day
44	2	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Daniel Dolan
13. Birthplace Unknown

MOTHER
14. Maiden Name Mollie Daywald
15. Birthplace Unknown

16 (a) Informant Roland L. Benson
(b) Address 4018 Roland Ave

17 (a) Burial (b) Date thereof 6/11/45
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUN 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1945, at 4:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Schmidt M.D.
Medical Examiner.
Date signed 6/7/45

G29582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G29582

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5728 Uffington Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 5728 Uffington Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William E. Hearn

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Annie Owen Hearn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st 1874

8. AGE: Years	Months	Days	If less than one day
70	10	15	hr. min.

9. Birthplace Cambridge Md (Town, county, and state)

10. Usual Occupation Elks Secty

11. Industry or business Pocket Testament League

FATHER

12. Name Wm R. Hearn

13. Birthplace Md.

MOTHER

14. Maiden Name Florence Smoot

15. Birthplace Md

16 (a) Informant Chas. R. Hearn

(b) Address Wilmington Del

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/9/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cambridge Md

Location

18 (a) Funeral director William Cook Inc

(b) Address 217 St. Paul st.

19 (a) JUN 8 — 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 6/6 1945

and that I last saw him alive on 6/5 1945

Immediate cause of death

Congestive Heart Failure

Due to Arteriosclerosis

C-V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas. R. Hearman M. D.

Address 4037 Old Rd, Date signed 6/7/45

VS 150

X

M. D. B. 1268-9

G29583

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29583

CERTIFICATE OF DEATH

$5

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 2316 W. North Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Emma Hammers

(a) Residence: No. 2316 W. North Ave St., 15-3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles W. Hammers

6. DATE OF BIRTH (month, day, year) Mar 13th 1909

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	2	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Washington D.C.

FATHER

13. NAME Peter S. Baum

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Mary Oppermann

16. BIRTHPLACE (city or town) (State or country) Washington D.C.

17. INFORMANT Peter S. Baum

(Address) 2316 W. North Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Woodlawn Cem. Date 6/11 19 45

19. UNDERTAKER William Cook Inc

(Address) 1617 St Paul St

JUN 8 - 1945

20. FILED 19 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 7th, 1945

22. I HEREBY CERTIFY, That I attended deceased from July 1944 to June 7 1945

I last saw him alive on June 6, 1945; Death is said to have occurred on the date stated above, at 1 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Status Epilepticus	
Other contributory causes of importance:	
Epilepsy	ago

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W E Rudle M. D.

(Address) 2316 W. North Ave 6/7/45

(over)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G29584

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 N. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert N. Wilkinson

3 (b) If veteran, name war N | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Alma Wilkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12th 1885

8. AGE: Years 59 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name James L. Wilkinson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Workmon
15. Birthplace "

16 (a) Informant Alma L. Wilkinson
(b) Address 1 N. Ellwood Ave

17 (a) Burial (b) Date thereof 6/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) JUN 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1945, at 10 42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to June 5 1945, and that I last saw h/m alive on June 5 1945.

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Art Warts (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Watty A. Jackson M. D.
Address 200 Seamon Drive
Date signed June 6-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G29585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Walters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1888

8. AGE: Years 56 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Mary ???

15. Birthplace Baltimore, Md.

16 (a) Informant Ellis Walters

(b) Address 110 N. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8, 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Baltimore, Md.

18 (a) Funeral director Jno. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JUN 8 - 1945 (b) Registrar
Date received by registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1945, to June 4 1945, and that I last saw he alive on June 4 1945.

Immediate cause of death Carcinoma of Breast — Duration

Due to

Due to

Other Conditions Terminal Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Campbell

Address 844 N. Carey St Date signed 6/7/45 M. D.

Dr. Chalfonte
6210 York Road

629586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G29586

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 Micoll Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Nicoll Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary H. Borchers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Roland W. Borchers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1890

8. AGE: Years	Months	Days	If less than one day
55	6 5	5	hr. min.

9. Birthplace Philadelphia
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Goodwin
13. Birthplace Penn.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Phila.

16 (a) Informant Mr. Roland W. Borchers
(b) Address 500 Nicoll Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ /45 (month) (day) (year)
(c) Cemetery or crematory Westminister Cem.
Location Philadelphia

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 JUN 8 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7th, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1943 to June 7 1945 and that I last saw h-- alive on June 7 1945.

Immediate cause of death Carcinoma of breast — Duration 16 mos.

Due to —

Due to —

Other Conditions Cerebral metastases

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Carcinoma of breast

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Chalfonte M. D.

Address 6210 York Rd Date signed June 7 45

VS 150

G29587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G29587 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3515 Spaulding Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Morris Schiff SCHIFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 61 Months: Days: If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER

12. Name Jacob

13. Birthplace Russia

MOTHER

14. Maiden Name Hannah

15. Birthplace Russia

16 (a) Informant Mrs. Gertrude Schiff

(b) Address 3515 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)

(c) Cemetery or crematory Workman Circle

Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) JUN 8 1945 (b) Huntington, Williams, M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1945, at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1945 to 6/7 1945, and that I last saw h/m alive on 6/2 1945.

Immediate cause of death Cardiac Failure — Duration

Due to Cardiac failure

Due to hypertension C-V disease

Other Conditions Cerebral hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Simson M. D.

Address Sinai Hosp. Date signed 6/8/45

J. Simson

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

G29588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3742 Clarinth Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3742 Clarinth Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Julius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Julius Miller
(b) Address 3742 Clarinth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St.

19 (a) JUN 8 - 1945 (Date rec'd by registrar) (b) Registrar

Huntington Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7- 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10, 1939 to June 7, 1945; and that I last saw h[illegible] alive on June 6, 1945.

Immediate cause of death Cerebral Hemorrhage. — Duration about 3 yr.

Due to Arteriosclerosis Hypertension Myocarditis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan H. Shnitz, M.D. (M. D.)
Address 1810 Eutaw Pl. Date signed 6/7/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 G29584 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Moyer St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Moyer St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Tapper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-[illegible]-03

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Dispatcher

11. Industry or business Balto. Motor Coach

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Ida –
15. Birthplace Russia

16 (a) Informant Bertha Tapper
(b) Address 2112 Moyer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Donnel St.

18 (a) Funeral director Jack Louis Inc
(b) Address 1439 E. Baltimore St.

19 (a) [illegible] (b) [illegible]
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-45 19 , at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1945 to 6-7- 1945 and that I last saw h[illegible] alive on 6-6- 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension and Arteriosclerosis

Due to:

Other Conditions: Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
Address 234 S. Conkling St Date signed 6-7-45

X

G29590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G29590 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Municipal Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Belmont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Whitney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1945

8. AGE: Years	Months	Days	If less than one day
		27	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Leonard E. Whitney

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Lavinia Whitney Smith

15. Birthplace Baltimore Md

16 (a) Informant Hosp. Records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 6 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUN 8 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 26 1945, and that I last saw h alive on May 26 1945

Immediate cause of death	Duration
a Hydrocephalus	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Church M.D.

Address Univ Hosp Date signed 6-3-45

VS 150

55 X

29591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓159

E-29591

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Lanvale st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

7-2

3 (a) FULL NAME Baby Virgil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-45

8. AGE: Years	Months	Days	If less than one day
		1	27 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Stulta
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Madeline Virgil
15. Birthplace Washington D.C.

16 (a) Informant Madeline Virgil
(b) Address 624 Lanvale St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 15 1945 Hamilton Hathaway M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11 1945, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1945, to 6-11-1945, and that I last saw him alive on 6-11-1945.

Immediate cause of death

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Langston Trump M.D.
Address 1100 Druid Hill Ave Date signed 6/12/45

764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29592

J1 - 93779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G29592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Parker (Inez)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesse Parker
13. Birthplace Va.

MOTHER
14. Maiden Name Inez Boggs
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave. at 5:15 P.M.

17 (a) Cremated (b) Date thereof 6-6-45
~~(Burial)~~, cremation, ~~or removal~~ (month) (day) (year)
(c) ~~Cemetery or~~ crematory Balto City Hosp.
Location 4940 Eastern Ave

18 (a) ~~Funeral director~~ Balto City Hosp.
(b) Address (Record)

JUN 8 - 1945 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1945 to May 25 1945, and that I last saw h. im alive on May 25 1945.

Immediate cause of death	Duration
Congenital Syphilis	2 days
Due to	
Due to	
Other Conditions Premature F (2 Lbs)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Young Jr. M.D.
M. D.
Address Balto City Hosp. Date signed 6/6/45

X

G29593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G29593
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun.
(c) Hospital or institution: Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Eleven hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Eleven hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Ruxton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bellona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Denbow. | Denbow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1945

8. AGE: Years | Months | Days | If less than one day 9 hr. 28 min.

9. Birthplace Baltimore. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David B. Denbow
13. Birthplace Baby Boy Denbow Franklin Square Hosp. Baltimore Md

MOTHER
14. Maiden Name Helen R. McKelvin
15. Birthplace Baltimore Md

16 (a) Informant Hosp. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 8 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945 at 10:27 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945 to June 3 1945 and that I last saw h e alive on June 3 1945.

Immediate cause of death Premature baby.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Kerpman M. D.
Address Franklin Sq. Hosp. Date signed 6-3-45

756

G29594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G29594 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 S. Luzerne Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 South Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michalena Michalski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Frank
6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) July 1865

8. AGE: Years	Months	Days	If less than one day
79 80	11		hr. min.

9. Birthplace Poland.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Wladyslawa Roszko
(b) Address 2409 Fleet Street

17 (a) Burial (b) Date thereof 6-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanslaus
Location Baltimore-md

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) (b)
(Date rec'd by registrar) Registrar

JUN 8 - 1945

Substitute Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1945, at 11 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1945 6/6 1945
and that I last saw her alive on 6/6 1945.

Immediate cause of death:
Hypertension Cardio Vascular Renal - Cardiac
Due to Acute pulmonary Mitral Insufficiency
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Luther L. Leatherbrook M. D.
Address 1076 S. East Ave Date signed 6/7/45

G29595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G29595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Warner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Warner St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Ruffin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/1913

8. AGE: Years 31 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Elizabeth City NC (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charlie Griffin
13. Birthplace N C.

MOTHER
14. Maiden Name Dora Williams
15. Birthplace N C

16 (a) Informant Henry Ruffin
(b) Address 1120 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah F. Brown
(b) Address 10 E W Montgomery St

19 (a) JUN 8 - 1945 (Date rec'd by registrar) (b) Huntington Wilcox, Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4/45 19 , at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May N 19 45 to 6/4/45 19 , and that I last saw h. alive on 6/3/45 19 .

Immediate cause of death	Duration
Coronary Thrombosis	3 hrs.
Due to Arteriosclerosis of Both Lungs	24 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Lamm M.D.
Address 9 Eutaw Pl Baltimore Md Date signed 6-7-45

G29596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G29596 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St.
(c) Hospital or institution: Women's Hospital 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo 28d.
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Oakford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine (Katie) Christine King Smith
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	White	Married

6 (b) Name of husband or wife George R. Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-8-(1878)1875

8. AGE: Years	Months	Days	If less than one day
(66)69	8	29	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles King
13. Birthplace Washington

MOTHER
14. Maiden Name Matilda Simmons
15. Birthplace Balto.

16 (a) Informant Mr. George R. Smith
(b) Address 3106 Oakford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 3.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944, to June 7 1945, and that I last saw h.r alive on June 7 1945.

Immediate cause of death	Duration
Obstruction	
Due to Intestinal Obstruction	
Hydronephrosis and Hydronephrosis	
Due to Carcinoma of bladder.	7yrs +

Other Conditions Hypertension Cardio-Vascular Disease, Mild.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Good M.D.
Address Women's Hospital Date signed 6-7-45
M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43D

G29597
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Coldspring Lane
(c) Hospital or institution:
Coldspring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lloyd M. Ritter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1868

8. AGE: Years	Months	Days	If less than one day
76	9	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Oysterman
11. Industry or business

FATHER
12. Name John B. Ritter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Durm ~~Ritter~~
15. Birthplace Phila., Pa.

16 (a) Informant Wade H. Ritter
(b) Address 3912 Norfolk Ave.

17 (a) Burial (b) Date thereof 6/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JUN 8 - 1945
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 1b

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to June 7 1945 and that I last saw him alive on June 7 1945

Immediate cause of death Chronic myocarditis — Duration

Due to

Due to

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Cutterman M. D.
Address 2324 Reisterstown Rd. Date signed

X

G29598

CWK-93946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939

G29598

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 346 Westshire Road (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME John Lanhem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18-1872

8. AGE: Years	Months	Days	If less than one day
73	0	18	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name Benjamin Lanham

13. Birthplace Maryland

MOTHER

14. Maiden Name Annie ?

15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Md

18 (a) Funeral director Williams Cook & Son

(b) Address 217 St. Paul St

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

JUN 8 - 1945

VS-100

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945 to June 6 1945 and that I last saw h. im alive on June 6 1945.

	Duration
Immediate cause of death Congestive heart failure	
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions Bronchopneumonia	4 days

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature D. H. Rudolph M.D.

Address Balto City Hospitals Date signed 6-7-45

G29599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29599

Registered No. 1084

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1327 - Hollins St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Yolanda Cecelia Schultz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5th 1944

8. AGE: Years	Months	Days	If less than one day
	6	1	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name W. J. Russell Schultz

13. Birthplace Balto

MOTHER

14. Maiden Name Yolanda Trizzi

15. Birthplace Balto.

16 (a) Informant W. J. Russell Schultz

(b) Address 1327 - Hollins St Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/'45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Edmondson Road

18 (a) Funeral director Robert Lowman Sons

(b) Address 901-03 Hollins St

19 (a) (Date received by registrar) (b) Huntington Williamsport, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to June 6 1945, and that I last saw h[illegible] alive on June 6 1945.

Immediate cause of death Resp. failure

Jaundice

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. J. Robey

Address Date signed 6/12/45

X

G29600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G29600 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1897

8. AGE: Years	Months	Days	If less than one day
47	8	23	hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mamie Mosley
(b) Address 523 S Greene Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City Md.

18 (a) Funeral director Joseph A. Sisly
(b) Address 41 S Mount Street

19 (a) (Date received by Registrar) JUN 8 1945 Registrar

VS 1ST

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 5-05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to expiration of blood

Due to Multiple lacerations of face & mouth

Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 4 1945 18/21 P.M.
(b) Where did injury occur? Arlington Ave & Franklin St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed June 4 1945

Huntington Williams, M.D.

G29601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

Registered No. G29601

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & Jolly St.

(c) Hospital or institution Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(b) City or town Baltimore — 10
(If outside city or town limits write RURAL and give town)

(d) Street No. 500 Overhill Rd.
(If rural give location)

(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME MISS GERTRUDE HELENE LINDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1875

8. AGE: Years	Months	Days	If less than one day
69	9	9	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name ?

13. Birthplace Germany

MOTHER 14. Maiden Name Augusta ?

15. Birthplace Germany

16 (a) Informant Mrs. Louisa Bunby

(b) Address 500 Overhill Rd Balto-10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9 1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director John G Moran

(b) Address 3000 E Baltimore St

19 (a) (Signature of registrar) Huntington Williams M.D. Registrar

JUN 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 10 25 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 June 1945, to 7 June 1945, and that I last saw h[illegible] alive on 7 June 1945

Immediate cause of death possible coronary occlusion — Duration

Due to Hypertensive C.V.D. & auricular fibrillation.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation?

Major findings of operation? arteriosclerosis, hypertrophy, with dilatation (old)

of autopsy? hydropericardium

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. Richard Compton M.D.
M. D.

Address Hosp. for Women Date signed 8 June 45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29602
AB-93796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G29602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Arch St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ila Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ?-1904

8. AGE: Years	Months	Days	If less than one day
41	0	?	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Bishop
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Walker
(b) Address 1900 Bentley ave

19 (a) JUN 8 1945 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6- 1945, at 11.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24- 1945, to 6-6 1945, and that I last saw him alive on 6-6- 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	(2)
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions Tuberculosis pentastitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Leonard M.D.
Address Balto, Md. Date signed 6/5/45

VS 150

G29603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G29603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE C. RUFENACHT

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Wm. H. Rufenacht
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 29, 1905
8. AGE: Years 39 | Months 4 | Days 8 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Hines
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Pauline Oppel
15. Birthplace Balto., Md.

16 (a) Informant Mr. Wm. H. Rufenacht
(b) Address 2706 Montebello Terrace

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lasaahn Funeral Home
(b) Address 7401 Belair Road Huntington Williams, Mgr.

19 (a) JUN 8 - 1945 (Month and day registered) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to June 7 1945, and that I last saw h[illegible] alive on June 5 1945.

Immediate cause of death	Duration
Chronic myocarditis	5 years
Due to	
Due to	
Other Conditions Thrombocytopenic Purpura Died at home, June 7, July 9 1944 (Include pregnancy within 3 months of death)	

Date of operation none
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence none at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Gordy M.D.
Address 5106 Harford Road M. D.
Date signed 6/7/45

VS 3

MARY G.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E ✓

Registered No. 629604

629604

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5017 Belair Rd
(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 48yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 48yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5017 Belair Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary G. Hollander

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife Eli Hollander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1883

8. AGE: Years	Months	Days	If less than one day
62		20	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Arnaub
13. Birthplace Pa

MOTHER
14. Maiden Name Jana Cousler
15. Birthplace Pa.

16 (a) Informant Mrs. John Harris
(b) Address 5017 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Sasscha Funeral Home
(b) Address 7401 Belair Rd.

19 (a) JUN 8 - 1945 (Date rec'd by local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to June 6 1945, and that I last saw h[illegible] alive on June 6 1945.

Immediate cause of death Myocarditis
Terminal Bronchopneumia — Duration 2 yrs 2 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 4930 Belair Rd Date signed June 7, 1945

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G29605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Fleetwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Fleetwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anna S. Killian

3 (b) If veteran, name war —

3 (c) Social Security Account No. Nine

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John F

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1877

8. AGE: Years 67 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Jas. Kaspar
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Brabec
15. Birthplace Bohemia

16 (a) Informant John F. Killian
(b) Address 4008 Fleetwood Ave.

17 (a) Burial (b) Date thereof 6/11/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director W. W. W. E. Dipple's Sons
(b) Address 409 Saratoga St.

19 JUN 8 - 1945 Huntington Williams, M.D.
(Date rec'd by local reg.)

MEDICAL CERTIFICATION

55

20. DATE OF DEATH June 7 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1945 to 6-7 1945 and that I last saw her alive on 6-7 1945.

Immediate cause of death Cerebral Anemia — Duration

Due to Cerebral Vascular accident (embolus)

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 6-7-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G29606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 757 Bradley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 757 Bradley
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Cole

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F

5. Color or race C.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1889

8. AGE: Years 55 | Months 6 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alex. McKinney
13. Birthplace W. Va.

MOTHER
14. Maiden Name Lucy Drew
15. Birthplace W. Va.

16 (a) Informant Anna Cole (Granddaughter)
(b) Address 757 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location Balto. Md.

18 (a) Funeral director Charles Glover
(b) Address 501 N. Carrollton Ave.

19 JUN 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945 to June 5 1945.
and that I last saw her alive on June 1945.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Casey M. D.

Address 757 Bradley St. Date signed 6/8/45

VS 150

G29607

BALTIMORE CITY HEALTH DEPARTMENT ✓ G29607

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Bank Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Bank Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Rakowski

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Paul

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 23, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	12	....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Julius W. Schulz
13. Birthplace Danzig, Germany

MOTHER
14. Maiden Name Catherine Bremer
15. Birthplace Poland

16 (a) Informant Mr. Paul Rakowski
(b) Address 1709 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) JUN 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 9 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 4 1945, to June 5 1945, and that I last saw her alive on June 5 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nelson J. Solomon M.D.
Address 129 S. Paca Date signed 6/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 V

Registered No. G29605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 N. 33rd St.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 W. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Gibson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1865

8. AGE: Years 79 Months 10 Days 5 If less than one day hr. min.

9. Birthplace Randolf Co. W. Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Adam Fansler
13. Birthplace W. Va

MOTHER
14. Maiden Name Judith Phillips
15. Birthplace W. Va.

16 (a) Informant Mrs James Eberly
(b) Address 624 W. 33rd St.

17 (a) Removal (b) Date thereof 6/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maplewood Cem
Location Elkins, W. Va.

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road.

19 (a) Date of registration JUN 8 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to June 7 1945 and that I last saw her alive on June 7 1945

	Duration
Immediate cause of death Myocardial insufficiency	5 days
Due to Arterio Sclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Barnes M. D.
Address 800 N 33rd St Date signed 6-8-45

X

G29609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 E

G29609
Registered No. (wa)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Wilcox St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Wilcox St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-2210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of ~~husband~~ or wife Leona
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1899

8. AGE: Years	Months	Days	If less than one day
46	3	6	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace Va

16 (a) Informant Leona Smith
(b) Address 1301 Wilcox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Taylor Ave

18 (a) Funeral director Leo S. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by local registrar) JUN 8 1945 (b) Huntington Ave Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1943, to 6/8 1945, and that I last saw h/Ma alive on 6/3 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden.
Due to Cystic Condition.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 1206 E Fenton St Date signed 6/7/45

X

G29610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G29610 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 S. Conkling St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 901 S Conkling St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine Reimer

3 (b) If veteran, name war -

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Reimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER

12. Name John Czyzechowicz

13. Birthplace Poland

MOTHER

14. Maiden Name Anna Rozanyelski

15. Birthplace Poland

16 (a) Informant Ed Czyzechowicz

(b) Address 240 S Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9 45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W Ozdzenski

(b) Address 1930 Eastern Ave.

19 (a) (Date received by registrar) JUN 8 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 5 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/15 1945 to 6/6 1945 and that I last saw h[illegible] alive on 6/6 1945

Immediate cause of death Cerebral Hemorrhage — Duration 7 day

Due to

Due to

Other Conditions

* (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter L Swartzman M. D.

Address 1076 S. Eastern Date signed 6/8/45

Huntington Williams, M.D.

G29611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G29611 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918. Herbert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 "
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1918. Herbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John. Ce. Mc. Cormick

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.:

4. Sex: Male.
5. Color or race: White.
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24. 1861

8. AGE: Years 83. Months 9 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House. Painter
11. Industry or business Work. for. self.

FATHER
12. Name William H. McCormick
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Auburn
15. Birthplace " " "

16 (a) Informant Julia. Ferraro
(b) Address 1918. Herbert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Western. Cem.
Location Edmondson. ave

18 (a) Funeral director Wendell Disque
(b) Address 3145. Highland Ave.

19 (a) JUN 8 1945 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945 At 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ✓ 19 , to ✓ 19 , and that I last saw h alive on ✓ 19 ✓.

Immediate cause of death Coronary Occlusion — Duration Sudden

Due to Aortic Sclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Howard M.D.
Address 4 Mt. Vernon Pl. Date signed 6-7-45

VS 150

X

G29612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G29612 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 56 x 6 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Washington Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Hattie Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-1875

8. AGE: Years 69 | Months 6 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Restaurant owner

11. Industry or business

FATHER 12. Name Wm Smith
13. Birthplace Eng

MOTHER 14. Maiden Name Georgianna Brothers
15. Birthplace Delaware

16 (a) Informant Katherine Fink
(b) Address 1713 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6. 9. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Martin & Conroy
(b) Address 1600 Hollins St.

19 (a) 6-8-1945 (Date rec'd by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6- 1945, at 3 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5- 1945, to 6-6- 1945 and that I last saw h/m alive on 6-6- 1945

Immediate cause of death: Portal Cirrhosis — Duration 3 H-Syrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Erlich M. D.
Address 1213 Light St. Date signed 6-6-45

VS 150

X

G29613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29613 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2058 - Kennedy Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Delaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jeremiah Delaney
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Clark
15. Birthplace Ireland

16 (a) Informant Ann Foy
(b) Address 2308 - Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.,
Location

18 (a) Funeral director Mary M. Mayfield
(b) Address 321 E. 22nd St.

19 (a) 6-9-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945, to June 6 1945, and that I last saw h alive on June 6 1945.

Immediate cause of death Respiratory failure

Due to Cerebral accident

Due to Arteriosclerotic C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Roffer

Address Date signed 6/9/45 (M D)

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G23614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G23614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1425 Hull St.
(c) Hospital or institution:
24 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Hull St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Michael J. Flynn

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 215-05-7855
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 17 1898
8. AGE: Years 47 Months 1 Days 21 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Steamship Clerk

FATHER
12. Name Michael J. Flynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Harg
15. Birthplace Ireland.

16 (a) Informant James Flynn (Brother)
(b) Address 1425 Hull St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.
18 (a) Funeral director Flynn & Flanagan
(b) Address 1426 Light St.
19 (a) (Filed) JUN 9 - 1945 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1945, to June 7 1945, and that I last saw him alive on June 7 1945.

	Duration
Immediate cause of death: Lobar Pneumonia	2 days
Due to: Influenza	8 days
Due to: Acute Myocarditis Decompensatio	6 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. P. A. Stevens
Address 2878 Harford Rd Date signed 6/8/45 M. D.

X

G29615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29615 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH B. WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George T. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1886

8. AGE: Years	Months	Days	If less than one day
59	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Eberts
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. George T. Williams
(b) Address 2229 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 9 - 1945 (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1945 to 6/8 1945, and that I last saw her alive on 6/8/45 19

Immediate cause of death	Duration
acute vascular disease	2 yrs
Due to	
Due to	
Other Conditions cerebral hemorrhage	2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2030 Eutaw Pl. Date signed 6/6/46

all X

G29616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G29616

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 Mt. Holly St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d

(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard J. Newett

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Higginson Newett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1893.

8. AGE: Years 51 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation U.S. Imigration Inspector

11. Industry or business U. S. Govt.

FATHER
12. Name John Newett
13. Birthplace England

MOTHER
14. Maiden Name Helen Early
15. Birthplace England

16 (a) Informant Mrs. Alice H. Newett
(b) Address 324 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Little
(b) Address 4101 Edmondson Ave

JUN 9 1945 (Date rec'd by Registrar) (b) Hunting for Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to June 7 1945, and that I last saw h alive on June 7 1945

	Duration
Immediate cause of death Coronary thrombosis	June 7 hrs
Due to Coronary heart disease	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Roach
Address 3629 Edmondson Ave Date signed 6/7/45

T. E. Roach X

G29617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29617 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Augusta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 609 Augusta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Royster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1902

8. AGE: Years	Months	Days	If less than one day
43	3	2	hr. min.

9. Birthplace Va (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Dotson Davis

13. Birthplace Va

MOTHER 14. Maiden Name Camilla Jefferson

15. Birthplace Va

16 (a) Informant Sallie Johnson

(b) Address 609 Augusta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto. County, Md

18 (a) Funeral director Joseph B. Locke Jr

(b) Address 1204 N. Central Ave

19 (a) JUN 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1945, at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 6/7 1945, and that I last saw h alive on 6/7 1945.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	1 hr.
Due to (b) Essential Hypertension	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Lapp M.D.

Address 822 N. Bond Date signed 6/9/45

VS 180

X

G29618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G29618 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Jerome + Redwood Sts
(b) Street address University Hosp.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances B Fitzpatrick

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph J. Fitzpatrick
6 (c) If alive, give age 1879

7. Birth date of deceased (mo., day, yr.) Mar 4 1874

8. AGE: Years	Months	Days	If less than one day
66 67	3	4	..... hr. ..... min.

9. Birthplace Elmira N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Brian Costello
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Rose Carpenhaver
(b) Address 111 S. Stricker St

17 (a) Burial (b) Date thereof 6-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo L. Boyer Jr
(b) Address 1512 Hollins St

19 (a) Registered JUN 9 1945 Hunting for Wm
(Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8 1945, at 5 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1945 to 6/8 1945, and that I last saw her alive on 6/7 1945.

Immediate cause of death Respiratory failure — Duration .....

Due to Carcinoma of Ovaries — .....

Due to ..... — .....

Other Conditions ..... — .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operations: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Charles D Clapp M. D.
Address University Hospital Date signed 6/8/45

X

OVER

G29619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G29619 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Bon Secours Hosp.
(c) Hospital or institution: 2025 W Fayette St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) One day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 W FRANKLIN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES C. HUM (CASPAR)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-40-3684

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/81

8. AGE: Years 63 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Dairy Business

FATHER
12. Name James Hum
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Reilworth
15. Birthplace Germany

16 (a) Informant Mrs. Barbara Heidrick
(b) Address 1833 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Geo. L. Boyer Jr
(b) Address 1512 Hollins St

19 (a) JUN 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 19 45 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 19 45, to 6/7 19 45, and that I last saw him alive on 6/7 19 45.

Immediate cause of death: UREMIA — Duration

Due to: HYPERTENSIVE CARDIO-RENAL DISEASE -

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis L. Grumbine M. D.
Address Bon Secours Hosp. Date signed 6/7/45

VS 150

G29620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No. G29620

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green Spring & Belvedere Ave

(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 17 Green Spring & Belvedere Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Louis Zussman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER

12. Name

13. Birthplace Russia

MOTHER

14. Maiden Name

15. Birthplace Russia

16 (a) Informant Levindale

(b) Address Grn Spring Lane & Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-45 (month) (day) (year)

(c) Cemetery or crematory Arlington Cemetery

Location Russia Ave

18 (a) Funeral director Jos Levin Inc

(b) Address 1439 E. Balto St

19 (a) JUN 9 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 9.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17-45 to 6-8 1945, and that I last saw h alive on 6-8 1945

Immediate cause of death Carcinoma of stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Levin

Address Levindale Date signed 6/8/45

Manuscript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 c

G29621 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 West North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret A. Faithful
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/4/1867
8. AGE: Years 58 | Months 2 | Days 4 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Edwin Faithful
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret a Goss
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Jessie Walters
(b) Address 1602 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.

18 (a) Funeral director Duanire Cook Eyfer
(b) Address 1600 W. North Ave

19 JUN 9 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945 at 5:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 8 1945 and that I last saw her alive on June 7 1945

Immediate cause of death: Chronic endocarditis — Duration: Years / Months / Days
Contributory Cerebral Hemorrhage
Due to Rheumatism
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X C Stovall
Address 1600 W North Ave Date signed June 8/45

X

G29622 D. Watts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. G29622

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Henley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Elmira

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-16-1881

8. AGE: Years 63 | Months 6 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Aiken S. C. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Louis Henley
13. Birthplace S.C.

MOTHER
14. Maiden Name Elizabeth McCoy
15. Birthplace S.C.

16 (a) Informant Mildred H. Cromwell
(b) Address 726 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Baltimore Md

18 (a) Funeral director Williams Jackson
(b) Address 916 Pennsylvania ave

19 JUN 9 - 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 3:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to June 8 1945 and that I last saw h[e] alive on June 8 1945.

Immediate cause of death Coronary Thrombosis

Due to cerebral disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 9 Mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Watts M. D.
Address 515 Huntington Ave Date signed 6/8/45

X

W 629623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

G29623 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. State correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St
(c) Hospital or institution Womans Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Liberty Road, North Bend
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE NISSELL ALLEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife Gilbert H. Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-21-67

8. AGE: Years	Months	Days	If less than one day
78	0	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Store Keeper
11. Industry or business

FATHER
12. Name John Adam
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Reitz
15. Birthplace Germany

16 (a) Informant Miss Christine Nissell-sister
(b) Address Liberty Rd. North Branch, Md.

17 (a) Burial (b) Date thereof 6-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JUN 9 - 1945 Huntington Williams, M.D.
Date rec'd (Local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 2:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945, to June 6 1945, and that I last saw her alive on June 6 1945.

Immediate cause of death Acute pulmonary Embolism — Duration

Due to Thrombosis, Lower extremity

Due to Arteriosclerotic Heart disease

Other Conditions Arteriosclerosis, generalized

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirms.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. S. Speed III
Address Women's Hospital Date signed 6-8-45 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

X

G29624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G29624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Patapsco Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) died 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Jack St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erma E. Dubroka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1918

8. AGE: Years 26 | Months 5 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Masontown, Penna.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business -

FATHER
12. Name Dazie Badrow
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary Stanbaud
15. Birthplace Pennsylvania

16 (a) Informant John Dubroka
(b) Address 800 Jack St.

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 6/9/45 (month) (day) (year)

(c) Cemetery or crematory J. Mory
Location Masontown, Pa.

18 (a) Funeral director Wilhorn Co. Inc.
(b) Address 3447 Pont St.

19 (a) JUN 9 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1945, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Spontaneous Cerebral Hemorrhage.

Due to Ruptured aneurysm

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mathis M.D.
Medical Examiner.
Date signed 6-9-45

VS 151

G29625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (53)

Registered No. G29625

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Ave.
(c) Hospital or institution: St Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3737 10th St (25) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Waterbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Leona

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1890

8. AGE: Years	Months	Days	If less than one day
54	7	7	hr. min.

9. Birthplace Roby N.Y. (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Lighthouse Service

FATHER
12. Name Stephen B Waterbury
13. Birthplace N.Y.

MOTHER
14. Maiden Name Keto (Unknown)
15. Birthplace N.Y.

16 (a) Informant Mrs Leona
(b) Address St Agnes Hosp

17 (a) Burial (b) Date thereof 6/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ravenna
Location Ravenna O.

18 (a) Funeral director Wilson Funeral Home
(b) Address 1314 E Fort Ave

19 (a) JUN 9 1945 (b) Huntington Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1945, to June 8 1945, and that I last saw h[illegible] alive on June 8 1945.

Immediate cause of death	Duration
Metastatic Carcinoma of Brain	
Due to Colonic Carcinoma	
Due to Left Antrum	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address St Agnes Hosp Date signed 6/8/45

VS 150

G29626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G29626

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 14 16 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Rosedale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Clifton Noah Hedley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma T. Hedley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Capt.
11. Industry or business Balto. Fire Dept.

FATHER
12. Name Wm. T. Hedley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rebecca Lowe
15. Birthplace Brewerytown Pennsylvania

16 (a) Informant Mrs. Emma T. Hedley
(b) Address 1500 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 6-12-45 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1945 to 6-8-1945 and that I last saw h~~im~~ alive on 6-8-1945

Immediate cause of death Cardiorespiratory Failure — Duration
Due to Carcinoma of Colon
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 5-25-45
Major findings of operation: Adenocarcinoma of Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm W. Hedley M. D.
Address Union Mem. Hosp. Date signed 6/8/45

VS 150

G29627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 65435 G29627

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Parkway
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mo18da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8mos 18day

2. USUAL RESIDENCE OF DECEASED:
(a) State Massachusetts (b) County
(c) City or town Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. USCG Harbor Patrol
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Guinivan, Francis Alan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Guinivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1877

8. AGE: Years	Months	Days	If less than one day
67	5	25	hr. min.

9. Birthplace Beverly, Massachusetts
(Town, county, and state)
10. Usual Occupation Seafaring
11. Industry or business

FATHER
12. Name David H. Guinivan
13. Birthplace Manchester, Mass.

MOTHER
14. Maiden Name Mathilda Curry
15. Birthplace Boston, Massachusetts

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof June 9-1945 (month) (day) (year)
(c) Cemetery or crematory Boston Mass.
Location
18 (a) Funeral director Roff Co B. M. Walters
(b) Address Pratt & Stricker Sts
19 (a) (b) Registrar

JUN 10 1945
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1944 to June 9 1945, and that I last saw him alive on June 9 1945

Immediate cause of death Adeno Carcinoma of Cecum — Duration 18 mos.

Due to — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 26, 1944

Major findings of operation: Exploratory laparotomy, Resection of cecum.

Exc. of post operative scar of abd. wall, 4/5/45 closure of colostomy

Date of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
Address U. S. Marine Hospital Date signed 6/9/45
Baltimore 11, Maryland.

G29628 CERTIFICATE CORRECTED 8-7-53 ✓ G29628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rena K. DeLashmutt

3 (b) If veteran, name war

3 (c) Social Security Account No. 200-10-3092

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Frank D. DeLashmutt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housework. Part Time
11. Industry or business Sales Lady

FATHER
12. Name William Knill
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Wolfe
15. Birthplace Maryland

16 (a) Informant Mrs Yvonne DeLashmutt
(b) Address 1923 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Grove
Location Elkwood, Howard Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md

JUN 10 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-1945 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3-1945 to 6-7-1945 and that I last saw h[illegible] alive on 6-7-1945

Immediate cause of death Respiratory Failure — Duration
Due to Pneumonitis Peritonitis
Due to Hypertensive Cardio Vascular Disease
Other Conditions Operation — Supra vaginal hysterectomy
(Include pregnancy within 3 months of death)
Date of operation May 28, 1945
Major findings of operation: Fibroid uterus, cyst of both ovaries
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Adams
Address West Baltimore General Hospital Date signed 6/7/45

Spec—12-23-2 E.B.R.S.—400 Bks.

G29629 HEALTH DEPARTMENT—CITY OF BALTIMORE G29629

CERTIFICATE OF DEATH. 13-1 832

1-PLACE OF DEATH

City of BALTIMORE: (No. 2505 Brookfield Ave St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Isaac Greenbaum

(a) Residence No. 2505 Brookfield Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Esther

6-DATE OF BIRTH (month, day and year) 1865

7-AGE.	If LESS than 1 day,
80 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, Harris Greenbaum

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Fannie Leder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Mrs Esther Greenbaum

(Address) 2505 Brookfield Ave

Filed JUN 10 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/8/45

17- I HEREBY CERTIFY, That I attended deceased from May 27 19 45 to June 6 19 45

that I last saw h[illegible] alive on June 8 19 45

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. M. Greenbaum M. D.

6/7, 19 45 (Address) 4 E 3 East Lafayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Hebrew Washington Road	June 11 19 45

20-UNDERTAKER.	ADDRESS
Sol Levinson & Bros	1126 W North Ave

X

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G29630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G29630

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2621 Springhill ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2621 Springhill ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Sarah Molly Brecker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Surgeon Zalman Brecker

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
74	—	—	hr. — min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name Shmual Zalmon Goldberg

13. Birthplace Russia

MOTHER

14. Maiden Name Minnie Fazer

15. Birthplace Russia

16 (a) Informant Mrs Cecilia Kopfing

(b) Address 2312 Mt Royal Ter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10/45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale

Location Hamilton ave

18 (a) Funeral director S. H. Levinson Bro

(b) Address 1124-26 W North ave

19 (a) JUN 10 1945 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 8:00 A.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from June 1 1945, to June 8 1945, and that I last saw h— alive on June 8 1945

Immediate cause of death Arterio Sclerosis, Myocarditis

Cerebral hemorrhage

Due to	Duration
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Benjamin Kadin M. D.

Address 2306 Eutaw Pl Date signed 6-8-45

X

G29631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓ G29631 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Reisterstown Rd Dis
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2708 Reisterstown Rd~~ 3301 Lighton Avenue
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Morris Katz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 47 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name Louis Abramovitz
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Etta
15. Birthplace Russia

16 (a) Informant Leon Hindin
(b) Address 3361 Lighton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10, 1945 (month) (day) (year)
(c) Cemetery or crematory ~~Har Zion Cemetery~~
Location Hamilton Ave Rosedale Cem

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUN 10 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. F. Rubenstein M.D.
Medical Examiner.
Date signed 6/14/45

G29632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

X ✓ G29632 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Apt 324 Westway Apts Middle Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarke J. Bishop
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Mary Riley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 29, 1916
8. AGE: Years 29 | Months | Days 10 | If less than one day ... hr. ... min.
9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Clarke W. Bishop
13. Birthplace Ohio

MOTHER
14. Maiden Name Alma E. Bayersdorfer
15. Birthplace Ohio

16 (a) Informant Mrs. Thomas J. Bishop
(b) Address 4982 Warsaw-Cleves Pike Cinn. Ohio
17 (a) Interment June (b) Date thereof 10, 1945 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory
Location Cincinnati, Ohio
18 (a) Funeral director C. W. Mears & Son
(b) Address 805 N. Calvert St.
19 (a) Filed JUN 10 1945 Huntington Williams, M.D. Registrar
(Date filed) (By registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 19 45 at 7:10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 19 45 to 6/9 19 45 and that I last saw him alive on 6/9 19 45

Immediate cause of death: Peritonitis — Duration: 2 days
Due to: following Cholecystectomy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Cholecystitis & Cholelithiasis
of autopsy: Peritonitis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jos. O'Leary & Chas. Dem. M.D.
Address St. Agnes Hosp. Date signed 6/9/45

VS 150

G29633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G29633 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Orleans St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May W. Spotten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. G. Spotten

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13-1868

8. AGE: Years 77 | Months 0 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Wm. G. Spotten
(b) Address 512 N. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave. & Gay St.

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 6 11 1945 (b) Huntington Williams, M.D. Registrar
(Date of day registered)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to 6-7 1945.
and that I last saw him alive on 6-6 1945.

Immediate cause of death Hypertension
Due to Cardio
Due to Coronary Thrombosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Yes
of autopsy:

Duration
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Angela M. D.
Address 2302 Dillon St. Date signed 6-8 1945

G29634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29634 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 S. Streeper St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MN (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 S. Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-9172

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth M.Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13-1889

8. AGE: Years	Months	Days	If less than one day
56	4	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Speddens Ship Yard

FATHER
12. Name James E.Brown
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Calligan
15. Birthplace Balto. Md.

16 (a) Informant Elizabeth M.Brown
(b) Address 930 S.Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Cem.
Location Taylor Ave.

18 (a) Funeral director John F. Miller
(b) Address 2654 Jefferson St.

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1945, at 5.21 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally, Medical Examiner.
Date signed 6/7/45

JUN 12 1945

G29635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G29635 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fader, Ben

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business ~~Retail Shoe~~ Grocer

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name China
15. Birthplace Russia

16 (a) Informant Maurice Fader
(b) Address 2043 Appleton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10-45 (month) (day) (year)
(c) Cemetery or crematory ~~Sinai Hosp~~ Garfield
Location Germany Hill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) Filed 6-10-1945 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9 1945, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 1945 to 6-9 1945 and that I last saw him alive on 6-9 1945.

Immediate cause of death: Circulatory failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome B. Dorfman M. D.

Address Sinai Hospital Date signed 6-9-45

G29636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29636

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Collins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Dina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1867

8. AGE: Years 78 | Months — | Days 20 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Burns
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Mc Cartley
15. Birthplace Ireland

16 (a) Informant Patrick Burns
(b) Address 2111 Collins Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof June 12 1945 (month) (day) (year)

(c) Cemetery or crematory Oakland
Location Baltimore Md

18 (a) Funeral director Geo. A. Fahey
(b) Address Fulton Ave. Fayette

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 10 1945

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1945 to 6/9 1945 and that I last saw him alive on 6/9 1945

Immediate cause of death Respiratory Failure — Duration

Due to Uremic Coma

Due to Arteriosclerosis Kidneys

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryson

Address St. Agnes Hospital Date signed M. D. 6/9/45

131a

G29637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G29637
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Potomac St. 5
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Elisabeth A. Spiegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1883

8. AGE: Years	Months	Days	If less than one day
62	1 2	1	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Floor Lady
11. Industry or business Tailor Shop

FATHER
12. Name John F. Spiegel
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Caroline S. Schaefer
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Bratten Jones
(b) Address 614 N. Potomac Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Luth.
Location Balto., Md.

18 (a) Funeral director Rosario Funeral Home
(b) Address 7401 Belair Road

19 (a) JUN 10 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May June 9, 1945, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2/ 1945, to 6/9/ 1945, and that I last saw her alive on 6/9/ 1945.

Immediate cause of death	Duration
Circulatory Failure	
Due to Severe Cachexia and Anemia	
Due to Carcinoma of Caecum.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Gen. Ca. and Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Scarr, M.D.
Address St. Joseph's Hospital Date signed 6/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G29638 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 S. HIGHLAND AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) ABOUT 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. HIGHLAND AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA B. ERHARDT

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife MICHAEL ERHARDT
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) FEB. 2, 1872

8. AGE: Years 73 | Months 4 | Days 5 | If less than one day ....hr. ....min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSE-WIFE

11. Industry or business AT HOME

FATHER
12. Name ? BERTHEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant GEORGE ERHARDT (SON)
(b) Address 713 S. HIGHLAND AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-11-45. (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM.
Location GERMAN HILL RD.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.

19 (a) .... (b) .... (Date received by registrar) Registrar

JUN 10 1945 Huntington Hillcoats, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 7 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945 to June 7 1945, and that I last saw h.... alive on June 7 1945

Immediate cause of death
Lobar Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon, M. D.
Address 129 S. Broadway Date signed 6/9/45

G29639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G29639 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Irving Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Markos Salomas
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Augustina
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 70 Months Days If less than one day hr. min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Open Heath Dayton Stables

FATHER
12. Name Wm. Salomas
13. Birthplace Greece

MOTHER
14. Maiden Name Mary ?
15. Birthplace Greece

16 (a) Informant Mr. Salvos Vardavas
(b) Address 735 Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 45 (month) (day) (year)
(c) Cemetery or crematory Greek Cem
Location Wilkens Ave. & Mill Rd.

18 (a) Funeral director J. J. Ellemann & Son
(b) Address 32 S. Broadway.

19 (a) (Date received by Registrar) (b) Registrar

JUN 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7 1945; at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 6/7 1945 and that I last saw him alive on 6/7 1945

Immediate cause of death Generalized carcinomatosis

Due to Carcinoma of head & pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. Abrams & Chambers M. D.
Address Date signed

X

G29640 G29640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Eutaw (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Rev Father Linford Bliss Everitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1890

8. AGE: Years	Months	Days	If less than one day
54	8	29	hr. min.

9. Birthplace Westfield Pennsylvania (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business Priest

FATHER
12. Name Wilbur Everitt
13. Birthplace New York

MOTHER
14. Maiden Name Clare Bliss
15. Birthplace New York

16 (a) Informant Patient
(b) Address See above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11 '45 (month) (day) (year)
(c) Cemetery or crematory Greek Mount
Location Balto Md

18 (a) Funeral director Henry F. Jenkins Sons Co
(b) Address Mc Cullough Orchard & Mt Washington

10 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8 1945, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1945 to 6-8-1945, and that I last saw h[illegible] alive on 6-6 1945

Immediate cause of death: Coronary occlusion — Duration 3 days

Due to hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Elmer Hardt, M. D.

Address C. M. H. Date signed 6-8-45

X

G29641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29641 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 Argonne Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 933 Argonne Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George R Hamann

3 (b) If veteran, name war W
3 (c) Social Security Account No. ---

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annie B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 21, 1865

8. AGE: Years 80 | Months | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Md

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Wilhelmina M Hamann
(b) Address 933 Argonne Drive

17 (a) Burial (b) Date thereof 6/11/45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1317 E Pont St

19 (a) (Date received by registrar) 10 1945 (b) Registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1943 to June 8 1945 and that I last saw h[illegible] alive on June 1 1945.

	Duration
Immediate cause of death Myocardial Degeneration	2 yrs +
Due to Coronary arteriosclerotic heart disease	2 yrs +
Due to	
Other Conditions Senility	—

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W Madden
Address 63 E Belvedere Date signed 6/9/45 M. D.

G29642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/131a

G29642 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 N. Carolina St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 N Carolina St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary J. EBY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife George W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1852

8. AGE: Years 93 | Months - | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name John File

13. Birthplace Penna.

MOTHER 14. Maiden Name Mary McClain

15. Birthplace Penna.

16 (a) Informant Mrs. Edna Eby

(b) Address 1722 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Lula Wiedefeld

(b) Address 914 Greenmount Ave

19 10 1945 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** June 9, 1945 at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9, 1945, to June 9 1945, and that I last saw her alive on June 8 1945.

Immediate cause of death. Arteriosclerotic C-V disease — Duration 6 mo

Due to Chronic Nephritis — 6 yrs

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm H. Strenger M.D.

Address 1402 E. Lanvale Date signed 6-9-45

X

G29643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1258

G29643 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Wicomico
(c) City or town Pittsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

PARENTS

FATHER
12. Name Burton Dunn
13. Birthplace Maryland

MOTHER
14. Maiden Name Anne Covington
15. Birthplace Maryland

16 (a) Informant University Hospital
(b) Address Redwood & Greene Sts.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-10-45 (month) (day) (year)
(c) Cemetery or crematory Salisbury
Location Salisbury Md.

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury Md.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) JUN 10 1945 Registrar

JUN 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to June 10 1945 and that I last saw him alive on June 10 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Acute myelogenous Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 7 1945

Major findings of operation: Hepatomegaly

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard T. Trabond Jr. M.D.
Address University Hospital Date signed 6/10/45

G29644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G29644 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2216 Roslyn Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Roslyn avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MOLLIE B. KATZENBERGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1868

8. AGE: Years	Months	Days	If less than one day
76	6	17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John H. Katzenberger
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary A. Bell
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Louis Katzenberger
(b) Address 2216 Roslyn avenue

17 (a) Burial (b) Date thereof 6/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son, Inc.
(b) Address 118 W. Mt. Royal Ave Huntington 0700 Baltimore, Md.

19 (a) 6-10-1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1945 to June 8 1945, and that I last saw h alive on June 7 1945

Immediate cause of death Cancer en Abdomen
Cavity

Duration
6 mos.
over

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John H Evans M. D.
Address 616 N 40 St Date signed

VS 150

G29645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓14

Registered No. G29645

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 S. Kresson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Kresson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Petty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21st 1944

8. AGE: Years	Months	Days	If less than one day
1	1	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Theodor Petty
13. Birthplace Chattanooga Tenn.

MOTHER
14. Maiden Name Geraldine Hawkins
15. Birthplace Chattanooga Tenn.

16 (a) Informant Theodor Petty (Father)
(b) Address 13 S. Kresson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13/45 (month) (day) (year)
(c) Cemetery ~~XXXXX~~ Forrest Hill
Location Chattanooga Tenn.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 Washington Blvd

19 (a) (b)
(Date received by registrar) Registrar

101945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 1945 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to 19, and that I last saw h — alive on 19

Immediate cause of death Tuberculous Meningitis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Thom M. D.
Address 321 Eutaw Pl Date signed

Approved: Robert Lee Graham M.D. June 10 1945

G29646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29646

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere + Greenspring and
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Silberman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 Months — Days — If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name David Silberman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Sara Zeskind
(b) Address 3618 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Date received by local registrar JUN 11 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-44 1944, to June 9 1945
and that I last saw h alive on June 9 1945

Immediate cause of death: Hypertension Chr. card. vas. disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M. D.
Address Levindale Date signed

VS 180

Sevel

G29647 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G29647

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Belvedere & Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Sevel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	W.

6 (b) Name of husband or wife: Late Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Jacob Cohen
13. Birthplace: Russia

MOTHER
14. Maiden Name: Annie Hanna Melnes
15. Birthplace: Russia

16 (a) Informant: Harry Sevel
(b) Address: Tyrone Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 11/45 (month) (day) (year)
(c) Cemetery or crematory: Anshie Emmeth
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-26 W. North ave.

19 (a) JUN 11 1945 (Registered) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 4.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1939 to 6-10 1945, and that I last saw h[er] alive on 6-10 1945.

Immediate cause of death: Hypertension Arteriosclerosis — Duration

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H Edmund Levin
Address: Levindale Date signed 6/10/45

G29648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Whitney Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Whitney Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wiley P. Clark

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-07-2856

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Josephine O. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/86

8. AGE: Years	Months	Days	If less than one day
59	2	23	hr. min.

9. Birthplace South Franklin township, Pa
(Town, county, and state)
10. Usual Occupation Bench Hand
11. Industry or business Glass Co

FATHER
12. Name Joseph Clark
13. Birthplace Buffalo Township Pa

MOTHER
14. Maiden Name Caroline Patterson
15. Birthplace South Franklin township Pa

16 (a) Informant Mrs Josephine Clark
(b) Address 2907 Whitney Ave

17 (a) Burial (b) Date thereof 6-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington Cem
Location Washington Pa.

18 (a) Funeral director Lorna Byers
(b) Address 5405 Park Heights Ave

19 JUN 11 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 1945, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 6/10/45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G29649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ Va (b) County
(c) City or town Gate City (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 41 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ruth, Mrs. William Arthur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Hannie L. Ruth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1863

8. AGE: Years	Months	Days	If less than one day
81	8	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Arthur Ruth
13. Birthplace Tennessee

MOTHER
14. Maiden Name Delia Hager
15. Birthplace Virginia

16 (a) Informant O. D. Ruth
(b) Address Gates City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 10 45 (month) (day) (year)
(c) Cemetery or crematory Gates City Cem
Location Gates City, Va.

18 (a) Funeral director Wm. J. Fichtner & Sons
(b) Address N. & Pennsylvania Aves.

19 JUN 11 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1945 to 6-9 1945 and that I last saw him alive on 6-9 1945

Immediate cause of death ? Pulmonary failure ~~embolism~~ Cerebral embolism ?

Due to Phlebitis Thrombosis Rt leg

Due to

Other Conditions Burn 3rd degree Left thigh (Include pregnancy within 3 months of death)

Date of operation 5-9-45

Major findings of operation Gangrene Amputation thigh Hypostatic pneumonia

of autopsy: None - Clinical

Duration
6 days,
a
4 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-6-45 at M
(c) Where did injury occur? Church Home Hosp (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury, Burned with hot water bottle

23. Signature Charles Thomas Ha Ch M. D.
Address C.H.H. Date signed 6-10-45

VS 150

For H. B. McNally, by Howard J. Morales, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a Registered No. G29650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3037 Hamilton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Hamilton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GUSTAV A. SEHLSTEDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Theresa M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30-1867

8. AGE: Years	Months	Days	If less than one day
78	1	8	hr. min.

9. Birthplace Cinn. Ohio
(Town, county, and state)

10. Usual Occupation Monument Maker

11. Industry or business

FATHER
12. Name John S. Sehlstedt.
13. Birthplace Sweden

MOTHER
14. Maiden Name Anna P. Blum
15. Birthplace Germany

16 (a) Informant Mrs James Tanner
(b) Address 2806 Hamilton Ave

17 (a) Burial (b) Date thereof 6-11-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Rusk
(b) Address 5305 Belair Road

19 (a) JUN 11 1945 Huntington Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8/45 19 , at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to Carbon Monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/4/45 about late afternoon
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Carriers on Trolley Car were injured.
(d) Means of injury Asphyxiated

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 6/9/45

VS 151

G29651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G29651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3037 Hamilton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA M. SEHLSTEDT Sehlstedt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Gustav A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 1869

8. AGE: Years 75 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Housewife.

FATHER
12. Name Rev. Stenzel
13. Birthplace Rumania ?

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Rumania ?

16 (a) Informant Mrs James Foure
(b) Address 3806 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ruck
(b) Address 305 Harford Rd

19 (Signature of local registrar) JUN 11 1945 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1945, at 7.40p M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to Carbon Monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/9/45 at about 4 to 5 AFTER NOON
(b) Where did injury occur? Home 27/4
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work?
(d) Means of injury Asphyxia burners on gas stove unlighted.

23. Signature John R. Dabis M.D. Medical Examiner
Date signed 6/9/45

G29652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41E

Registered No. G29652

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Knights of Columbus Hotel Madison & Cathedral Sts
(Or rural route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank X Knoerr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widow

6 (b) Name of husband or wife Katherine A. Knoerr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3 - 1872

8. AGE: Years	Months	Days	If less than one day
73	5	4	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Vice-Pres. Fraternity
11. Industry or business Fed. Savings & Loan Assn.

FATHER
12. Name Wm. John Knoerr
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Hartt
15. Birthplace Germany.

16 (a) Informant Mrs. Wm. Rogers
(b) Address Maynard Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) JUN 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1945 to June 7 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Carcinoma of Colon and generalized	?
Due to metastasis -	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M. D.
Address St. Agnes Hospital Date signed June 7, 45

VS 150

G29653 The

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G29653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex #21 (If outside city or town limits, write RURAL and give town)
(d) Street No. 371 Edgewater Apt. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7-1945

8. AGE: Years | Months | Days | If less than one day 12 hrs. min.

9. Birthplace West Balto. Gen. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stephen William Reed.
13. Birthplace Schenectady N.Y.

MOTHER
14. Maiden Name Jennie Veronica Slusky
15. Birthplace Schenectady N.Y.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 9 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 11 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 9 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1945 to 6/7 1945 and that I last saw h[illegible] alive on 6/7 1945

Immediate cause of death: Prematura — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward C. Doty M.D.

Address West Balto Gen Hosp Date signed 6/8/45 M D

VS 150

758

G29654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

G29654 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — OFFICIAL BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3529 Wabash Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Bargrosser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife PHILIP BARGROSSER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Shai -
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant Sam Bargrosser
(b) Address 3718 Oakfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodeph Shalom
Location

18 (a) Funeral director Jack Levine Ind.,
(b) Address 1439 E. Baltimore St

19 (a) JUN 11 1945 (b) Registered by Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 1 25 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained. Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 10 1945 12/11 14 M.
(b) Where did injury occur? Liberty Heights & Wabash Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes
(d) Means of injury Pedestrian struck by street car

23. Signature Robert Lee Gretter M.D. Medical Examiner.
Date signed June 10 1945

G29655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G29655 Registered No. 1312

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 N. Dallas St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1221 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ennis

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-10-6839

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lena Dockins
(b) Address 1037 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location O. G. County Md
18 (a) Funeral director Joseph B Lecky Jr
(b) Address 1304 N. Central Ave
19 (a) JUN 11 1945 (Registrar's signature) Huntington Maryland, Md Rayner Browne

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1945, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1944 to 6/6 1945 and that I last saw him alive on 6/3 1945.

Immediate cause of death: Hypertensive cardio-renal disease — Duration: 1 yr 9 mos
Due to
Due to
Other Conditions: bronchial asthma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1312 E. Madison St Date signed 6/8

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4756 29656 — BALTIMORE CITY HEALTH DEPARTMENT — 46 — G29656 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Mrs Eldenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leaton Aquilla

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-25-03

8. AGE: Years 41 | Months 11 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Aquilla
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor Rewis
15. Birthplace Md.

16 (a) Informant Reeves
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location O. A. County, Md.

18 (a) Funeral director Joseph D. Cook & Co
(b) Address 1304 N. Central Ave

19 (a) JUN 11 1945 (Date rec'd by registrar) Huntington Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 D S M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to June 9 1945, and that I last saw him alive on June 6 1945.

Immediate cause of death Pneumonia

Duration

Femoral arterial thrombosis

Ca of esophagus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-9-45

Major findings of operation: Thrombosis of femoral artery

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Mueller Jr. M. D.
The Johns Hopkins Hosp
Date signed 6-11-45

VS 150

G29657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 141F

Registered No. G29657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town WASHINGTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 - 1st ST. S.E. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Fairfax S. C. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Douglas Reeder
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace S. C.

16 (a) Informant Mr. Marcus G. Wood
(b) Address 433 - First St. S.E.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-45 (month) (day) (year)
(c) Cemetery or crematory Lincoln Mem. Park
Location Prince George Co. Md.

18 (a) Funeral director Mr. Francis J. Kenealy
(b) Address 578 W. Baltimore St.

19 (a) JUN 11 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Incomplete Abortion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 9 1945 ? M.
(b) Where did injury occur? ?
(c) Did injury occur at home, on farm, industrial place, in public place? ? While at work?
(d) Means of injury Instrumental dilatation & Curet

23. Signature Robert Lee Fraher M.D. Medical Examiner.
Date signed June 10 1945

914 Patapsco Ave
No. G29658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G29658 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Stone Court
(c) Hospital or institution: (Brooklyn) Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (Brooklyn)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Stone Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Faustina Tate

3 (b) If veteran, name war

3 (c) Social Security Account No. 191-01-1108

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Marcella

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) May 25 1907

8. AGE: Years 38 | Months — | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Blair County, Penna.
(Town, county, and state)

10. Usual Occupation Erector (Steel)

11. Industry or business Building Steel Erection

FATHER 12. Name Ira Tate
13. Birthplace Penna

MOTHER 14. Maiden Name Missouri Fonner
15. Birthplace Penna

16 (a) Informant Joseph Tate
(b) Address 1108 Stone Court Balto (Brooklyn) Md.

17 (a) Removal (b) Date thereof June 11 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wildenburg
Location Penna.

18 (a) Funeral director Wm Cook Jr.
(b) Address 1317 St Paul St Balto Md.

19 (a) JUN 11 1945 (Date rec'd by registrar) Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944 to June 9 1945 and that I last saw h[illegible] alive on June 9 1945

Immediate cause of death pulmonary edema — Duration

Due to heart failure — several years

Due to rheumatic heart disease — years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature J. Neumann

Address 914 Patapsco Ave Date signed 6-10-45
M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29659

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29659

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Hosp. for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted]

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Lowson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Fairmont Ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Carrie Parker Bay

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. M.
6 (b) Name of husband or wife Henry Clarkson Bay
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1881

8. AGE: Years 64 | Months 3 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business At Home

FATHER
12. Name Thomas Pierce
13. Birthplace Maryland

MOTHER
14. Maiden Name Georgianna P. Bond
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem. Location Towson, Maryland

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

19 (a) JUN 11 1945 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 at 12.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945, to June 9 1945, and that I last saw her alive on June 9 1945.

Immediate cause of death	Duration
Metastatic carcinoma to liver, stomach,	
Due to transverse colon, pancreas, etc. & primary	
Due to source not determined.	
Other Conditions Hypostatic pneumonia (terminal)	

(Include pregnancy within 3 months of death)

Date of operation 5/31/45
Major findings of operation: Metastatic carcinoma of liver, etc.
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest E. Bamfield M.D.
Address Women's Hosp. Date signed 6/9/45

X

G29660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G29660 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Place

(c) Hospital or institution: Elmhurst Nursing Home 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 734 E. Biddle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lewis N. Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth F. Mullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	15	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Carpenter & Builder (retired)

11. Industry or business

FATHER 12. Name Michael Mullen

13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Francis

15. Birthplace Maryland

16 (a) Informant George M. Mullen

(b) Address 530 Radnor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial

Location Taylor Ave.

18 (a) Funeral director John F. Denny, Inc.

(b) Address 795 Light St.

19 (a) (Date received by Registrar) JUN 11 1945 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1945, at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1945 to 6/8 1945, and that I last saw h/m alive on 6/8 1945.

Immediate cause of death: Arteriosclerotic Cardio-Vascular Renal Disease. — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph S. Blum M.D.

Address 1706 E. Baltimore St. Date signed 6/9/45

X

G29661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

Registered No. G29661

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 E. Montgomery St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 E Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick T. Turner

3 (b) If veteran, name war: Spanish Am. War.
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Nora Williams
6 (c) If alive, give age D years
7. Birth date of deceased (mo., day, yr.) April 12, 1861
8. AGE: Years 84 | Months 1 | Days 26 | If less than one day hr. min.
9. Birthplace Montgomery Co. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joshua T Turner
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Woods
15. Birthplace Unknown

16 (a) Informant Mrs William M Jones
(b) Address 120 E. Montgomery St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Ave
18 (a) Funeral director John F Henry Inc
(b) Address 718 Light St
19 (a) (b) (Date received by registrar) Registrar

JUN 11 1945 Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8th 1945 at 1 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to June 1945 and that I last saw him alive on 6/8/ 1945

Immediate cause of death: Coronary heart disease — Duration: 5 hrs

Due to

Due to Arterio sclerosis

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 121 W Mulberry St Date signed 6/15/45

G29662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

G29662

1. PLACE OF DEATH — Registered No. 351

CITY OF BALTIMORE: (No. 743 George St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Ida Lucas

If U. S. Veteran specify WAR ...

(a) Residence: No. 743 George St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, year) 1877

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Richmond Va

FATHER

13. NAME Daniel Green

14. BIRTHPLACE (city or town) (State or country) Richmond Va

MOTHER

15. MAIDEN NAME Mary Lampson

16. BIRTHPLACE (city or town) (State or country) Richmond Va

17. INFORMANT Madge Price.
(Address) 743 George St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Calvary Date June 11, 1945

19. UNDERTAKER Mrs. Katie D. Williams
(Address) 122 N. Schroeder St.

20. FILED JUN 11 1945 Registrar.

Huntington for Williams M.E.

VS 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 6-9, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 24 1945 to June 8 1945

I last saw her alive on June 7 1945 Death is said to have occurred on the date stated above, at 2:40 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Vascular Renal	

Other contributory causes of importance: Pernicious Anemia Cellulitis

Was an operation performed? No Date of ...

For what disease or injury? ...

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? No Date of injury ..., 19...

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?
... If so, specify ...

(Signed) H. S. Hawkins M. D.

(Address) 642 N. Eutaw

X H. S. Hawkins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G29663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1639

G29663
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olive C. Marr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1900

8. AGE: Years	Months	Days	If less than one day
45	3	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Attendant

11. Industry or business Johns Hopkins Hospital

FATHER
12. Name John Marr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susie Macy
15. Birthplace Hampton, Va.

16 (a) Informant Miss Marjorie C. Marr
(b) Address 605 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Maryland

Registered by

JUN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945, at 12:05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Rao death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sodium Fluoride Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-8-45 at 8.30 P. M.
(b) Where did injury occur? 605 St. Paul Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of "roach powder"

23. Signature Howard J. Bruneau M.D.
Medical Examiner.
Date signed June 9, 1945

G29664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945 Registered No. G29664

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3541 ParkHeights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3541 ParkHeights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Huss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 83 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Louis Huss
13. Birthplace Russia

MOTHER
14. Maiden Name Rose ?
15. Birthplace Russia

16 (a) Informant Albert B. Huss
(b) Address 6304 Wallis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 JUN 11 1945 (Entered by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION 7.40

20. DATE OF DEATH June 10 1945 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June-7-1945, to June-10-1945, and that I last saw him alive on June-10-1945.

Immediate cause of death: Coronary thrombosis — Duration: 4 days

Due to: General arterio sclerosis

Due to: hypertension

Other Conditions: prostatic obstruction
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Herman Seidel

Address 2404 Entaw Pl Date signed 6/11/45

VS 150

X

G29665

Louis HARMON. 48a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G29665

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eleanor Branam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ralph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1897

8. AGE: Years 47 Months 4 Days 1 If less than one day hr. min.

9. Birthplace Montgomery Co. Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Joshua Barnes
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Hattie Contee
15. Birthplace Charles Co. Md.

16 (a) Informant Ralph Branam
(b) Address 2410 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Geo. W. Hyldon
(b) Address 1631 Druid Hill Ave.

19 (a) JUN 11 1945 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7- 1945, at 9:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1945 to 6-8- 1945, and that I last saw h[illegible] alive on 6-8-45 19.

	Duration
Immediate cause of death Cardiac & Respiratory failure	
Due to Cancer of Cervix.	5 yrs.
Due to Fecal Calculomata.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2346 Madison Ave. Date signed 6-8-45

VS 8

G29666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29666 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 865 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 865 Harlem ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) **FULL NAME** Walter Jackson

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	widower

6 (b) Name of husband or wife Carrie V. Jackson
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	17	— hr. — min.

9. Birthplace Glendale, Prin. Geo Co. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Railroad

FATHER
12. Name Austin Jackson
13. Birthplace Glendale, Md.

MOTHER
14. Maiden Name Charlotte Matthews
15. Birthplace Glendale, Md

16 (a) Informant Hattie Dorsey Jones
(b) Address 1510 W. Lanvale St.

17 (a) Burial (b) Date thereof June 11, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs Lucy A. Stallard
(b) Address 1631 Druid Hill Ave

19 (a) ——— (b) ———
(Date rec'd by registrar) JUN 11 1945

VS : Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 June 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11.7.1936 to 6.7.1945 and that I last saw h[im] alive on 6.6.1945

Immediate cause of death	Duration
congestive heart failure	1.18.45
Due to Hypertensive heart disease	11.7.36
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M Fair M. D.
Address 400 N. Carrollton Ave Date signed 6.9.45

Glendale, Md

G29667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29667 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET JOHANNA IRWIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles Alexander Irwin
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Aug. 17. 1860

8. AGE: Years	Months	Days	If less than one day
84	9	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Not Known
15. Birthplace Marvland

16 (a) Informant Mrs. Lida Sunderland
(b) Address 3413 Ellamont Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway.

19 (a) (Date received by registrar) (b) Registrar

JUN 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9. 1945 at 9:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945, to June 9 1945, and that I last saw h[illegible] alive on June 6 1945

Immediate cause of death	Duration
Myocarditis	1 Mo.
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Janet Fisher M. D.
Address 1823 N. Mast. 24 Date signed 6/8/45

G29668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29668 Registered No. 1640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilmam Rd Drive
(c) Hospital or institution Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 E 29th St (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Ah-Lui-Ling

3 (b) If veteran, name war — no —
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race Yellow
6 (a) Single, married, widowed, or divorced Could not ascertain
6 (b) Name of husband or wife Don't know
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Abt 1908

8. AGE: Years Abt 37 | Months - | Days - | If less than one day ... hr. ... min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business —

FATHER
12. Name Could not ascertain
13. Birthplace China

MOTHER
14. Maiden Name Could not ascertain
15. Birthplace China

16 (a) Informant Chas Ming Chen (friend)
(b) Address 339-E-29-St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-45 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location New York. N.Y.

18 (a) Funeral director Stewart & Mahrle Co.
(b) Address 108 W North Ave.

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS JUN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8 1945, at 11:20 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to

Other Conditions Osteomyelitis of Jaw. Despondency
(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/8/45 at about 10:30 P M.
(b) Where did injury occur? Bathroom 3rd Floor of Marine Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Hung self by Electric Wire Cord

23. Signature H. J. Faulkner M.D.
Medical Examiner.
Date signed 6/9/45

G29669

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 93 D

G29669 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Columbia Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Wasch

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel M. Wasch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 11, 1873

8. AGE: Years 72 | Months — | Days 29 | If less than one day: hr. min.

9. Birthplace: Howard Co., Md. (Town, county, and state)

10. Usual Occupation: Real estate and
11. Industry or business: Insurance

FATHER
12. Name: Julius Wasch
13. Birthplace: Germany

MOTHER
14. Maiden Name: Augusta ?
15. Birthplace: Germany

16 (a) Informant: Mrs. Ethel M. Wasch
(b) Address: Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 12, 1945 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cem.
Location: Ellicott City, Md.

18 (a) Funeral director: Easton Sons
(b) Address: Ellicott City, Md.

19 (a) (Date rec'd by registrar) (b) Huntington, Md.

VS 150 JUN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9-45 19 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9- 1945 to 6-9 1945
and that I last saw h. alive on 6-9 19 45

Immediate cause of death	Duration
Congestive Heart Failure - Rt side	6 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury,

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 6-9-45

X

G29670 G29670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1344 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Booze

3 (b) If veteran, name

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-22

8. AGE: Years 22 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name Lillian Booze
15. Birthplace Md.

16 (a) Informant Lillian Booze
(b) Address 1344 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

(Date received) (b) Huntington Williams M.D. Registrar

JUN 11 1945

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-45 19 , at 8 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945, to June 7, 1945 and that I last saw h alive on 6-7-45 19 .

Immediate cause of death Pulm. Tbc. — Duration 2 wks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin Odum

Address 3/2 E 23rd St. Date signed M. 6 D. 1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

34-7977 G29671 1624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G29671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Wilmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. 2nd St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert M. Hunter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edna Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-78

8. AGE: Years 66 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Gasoline Station
11. Industry or business Operator

FATHER 12. Name Geo. Hunter
13. Birthplace Penn. -

MOTHER 14. Maiden Name Anna McCullen
15. Birthplace Penn. -

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)

(c) Cemetery or crematory
Location Wilmington Del.

18 (a) Funeral director Wm. J. Hickman Sons
(b) Address Wolcott & Va. Williams, Mgr.

19 JUN 11 1945 (Date rec'd by Registrar) (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945 at 11:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1945 to 6-10 1945 and that I last saw him alive on June 10 1945

Immediate cause of death: Cachexia — Abdominal Distension

	Duration
Due to Carcinoma of Colon	4 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Jackson M.D.
Address Johns Hopkins Date signed 6/10/45

G29672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G29672 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address M
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltinore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine C. Marshall

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jerome Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1858

8. AGE: Years 86 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Beckmyer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Knoblock
15. Birthplace Germany

16 (a) Informant Miss Bessie L. Marshall
(b) Address 634 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1945, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1945, to 6-10 1945, and that I last saw her alive on 6-10 1945

Immediate cause of death: Acute heart failure

Due to

Due to

Other Conditions: Fractured left femur
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence May 31 1945 at 3:30 P M
(c) Where did injury occur? 634 N. Fulton Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped + fell to floor.

23. Signature Jerome C. Marshall M. D.
Address Md. Gen. Hospital Date signed 6-10-45

For P. J. Sulinski, by Howard A. Mascio, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. G29673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Jamison Ave
(c) Hospital or institution: Pond Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S Ann (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Bernhardt Barnhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife John Barnhardt | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1855

8. AGE: Years 89 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Walter Scott
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca McClosky
15. Birthplace England

16 (a) Informant Henry Bernhardt
(b) Address 104 S Poloman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12 45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto

18 (a) Funeral director Wilkes Lund Hann
(b) Address 2008 Orleans St

19 (a) JUN 11 1945 (Date received) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 9 1945, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1945 to 6-9- 1945, and that I last saw h alive on 6-8 1945.

Immediate cause of death	Duration
Gen Arteriosclerosis	-
Due to Gangrene (dry) Rt foot	6 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2604 Garrison Blvd Date signed 6-9-45

VS 150

X

G29674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G29674
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3610 Esther Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Esther Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August C. Bukey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle V. Bukey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20-1878

8. AGE: Years	Months	Days	If less than one day
66	9	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Bukey
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Myrtle V. Bukey
(b) Address 3610 Esther Place.

17 (a) Burial (b) Date thereof June 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John L. Miller
(b) Address 2634 Jefferson St.

19 (a) JUN 11 1945 Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/45 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945 to 6/9 1945 and that I last saw h / m alive on 6/9 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular disease	
Due to	
Due to	
Other Conditions Contributory	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Townsend M.D.
Address 321 E. Eager St Date signed 6/10/45

X

G29675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G29675

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E + Calvert
(c) Hospital or institution: Union memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 [redacted] Union ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK Theodore Mc Quay

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-6466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Grace McQuay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-23-91

8. AGE: Years	Months	Days	If less than one day
54	0	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Ry. Express
11. Industry or business

FATHER 12. Name Mr. Rubin McQuay
13. Birthplace Md.

MOTHER 14. Maiden Name Annie Shipley
15. Birthplace ?

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto

18 (a) Funeral director Frank H Seitz
(b) Address 814 W Lafayette

19 (a) Date received JUN 11 1945 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6, 1945 to June 9 1945 and that I last saw h'm alive on 6-9 1945.

Immediate cause of death Respiratory failure — Duration

Due to Intra Cranial Hemorrhage

Due to Generalized Metastasis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 6/9/45

X

G29676

G29676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 3013 Windsor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. [redacted] Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Charles C. Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5-1881

8. AGE: Years	Months	Days	If less than one day
64.	4	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John N. Marley
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Loessel
15. Birthplace Md.

16 (a) Informant Mrs. Charles C. Gross
(b) Address 3013 Windsor Ave.

17 (a) Burial (b) Date thereof 6-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Baltimore

18 (a) Funeral director Leonard J. Kyck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 1 JUN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/ 1945 at 1:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [redacted] M.D.
Medical Examiner.
Date signed 6/16/45

D 29677 D29677.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County —
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Caroline Shoemaker

3 (b) If veteran, name war

3 (c) Social Security Account No. 146-18-9033

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. Shoemaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14-1866

8. AGE: Years 79 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Adam Bayer
13. Birthplace Germany.

MOTHER
14. Maiden Name Sophie Meister
15. Birthplace Germany

16 (a) Informant Ralph Shoemaker
(b) Address Drexel Hill Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 (month) (day) (year)
(c) Cemetery or crematory Fernwood Cem
Location Philadelphia Pa.

18 (a) Funeral director Geo. L Beyer Jr.
(b) Address 1512 Hollins St

19 (a) JUN 12 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to June 11 1945, and that I last saw h alive on June 9 1945.

Immediate cause of death Carcinoma of Right Breast — Duration 2 years

Due to

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? no
(b) Date of occurrence — at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature A. L. Gordon M.D.
Address 516 Harford Rd Date signed 6/12/45

MARGIN RESERVED FOR BINDING

"PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29678 Registered No. 166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.arrival
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED JONES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace I (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Dashiell's Funeral Home
(b) Address Princess Anne Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (month) (day) (year)
(c) Cemetery or crematory Princess Anne
Location Princess Anne Co. Md.

18 (a) Funeral director Jas. T. Kelsey
(b) Address 1313 Presstman

19 (a) JUN 11 1945 (b) Registrar
(Date received by registrar)
Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9:30 P.M. 6-10-45
(b) Where did injury occur? 1700 W. Lexington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot

22 Signature Robert L. Gutman M.D.
Medical Examiner.
Date signed June 11 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29679
475028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29679
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 E. Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Joseph Mick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-00

8. AGE: Years 44 | Months 7 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Merchant Seaman

11. Industry or business

FATHER 12. Name Simon H. Mick
13. Birthplace N.Y.

MOTHER 14. Maiden Name Gertrude Schmaing
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.G. Co. Md.

18 (a) Funeral director Fleming & Fleming
(b) Address 1476 Light St

19 (a) (Date received by Local Registrar) (b) Huntington Williams, Registrar

JUN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 1.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to June 8 1945, and that I last saw him alive on June 8 1945.

Immediate cause of death: Respiratory failure — Duration
Due to acute pulmonary edema
Due to Fracture fractional mucoid obstruction
Other Conditions ? lung abscess
Delirium Tremens
2 Transfusions (Blood) Penicillin

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Graham G. Vance M.D. 6/9/45
Address Johns Hopkins Hospital

Approved by Howard A. Kelly M.D.

2 G29680

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G29680 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 959 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 959 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Stratton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1907

8. AGE: Years	Months	Days	If less than one day
38	1	13	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charlie Watton
13. Birthplace Va.

MOTHER
14. Maiden Name Lovey Booker
15. Birthplace Va.

16 (a) Informant Blanche Stratton
(b) Address 959 N. Bond St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 12/45 (month) (day) (year)
(c) Cemetery or crematory
Location Meherrin Va.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1139 N. Carrollton St

19 (a) JUN 11 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6·5· 1945 to 6·10 1945 and that I last saw h— alive on 6·10· 1945

Immediate cause of death Acute myocarditis — Duration 1 Day

Due to Broncho Pneumonia — 5 Days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. G. LeCompte M. D.
Address 1420 E. Chase Date signed 6-11-45

G29681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G29681 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Rose

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 4 1880

8. AGE: Years 64 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER — 12. Name: Henry J. Helcine
13. Birthplace: Germany

MOTHER — 14. Maiden Name: Anna Miller
15. Birthplace: Balto. Md.

16 (a) Informant: Wm. J. McGuiness
(b) Address: 1929 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 12-45 (month, day, year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Road

18 (a) Funeral director: John A. Logan
(b) Address: 300 E. Balto. St.

19 (a) (Date rec'd by registrar) Registrar

JUN 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to June 9 1945, and that I last saw h[illegible] alive on June 9 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Chronic Myocarditis & Hypertension — Duration: [illegible]

Due to: — Duration:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lehmen M.D.

Address 1921 W Northern Date signed 6/9/45

G29682

BALTIMORE CITY HEALTH DEPARTMENT ✓ G29682

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 N. Wolfe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Seabreeze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Jas. Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6-1866

8. AGE: Years	Months	Days	If less than one day
79	1	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Patrick Arthur
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof May 12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John. A. Nolan
(b) Address 3010 E. Baltimore St

19 (a) 1945 (b) Washington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945 at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 6/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29683
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Jos. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rt. Rev. Msgr. John I. Barrett

3 (b) If veteran, name war

(c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1884

8. AGE: Years	Months	Days	If less than one day
61	1	28	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name John I. Barrett
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary A. Farrell
15. Birthplace Balto. Co. Md

16 (a) Informant Rev. Stanley Scarff
(b) Address 2521 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Fredrick Road

18 (a) Funeral director Peter J. Fahey & Sons
(b) Address 1318 Light St.

JUN 11 1945 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10-1945 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4-1945 to 6-10-1945 and that I last saw him alive on 6-10-1945

Immediate cause of death Congesting Heart Failure — Duration

Due to Hypertension

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank L. Vannix, M.D.

Address St. Jos Hosp. Date signed 6-10-45

93D

VS 180

G29684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

G29684 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Henry Wiemann

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-1521

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dolores Connolly

6 (c) If alive, give age 190 years

7. Birth date of deceased (mo., day, yr.) 8/24/1897

8. AGE: Years	Months	Days	If less than one day
53	9	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation R. R. Express Co.,

11. Industry or business

FATHER 12. Name John Wiemann

13. Birthplace Balto.

MOTHER 14. Maiden Name Margaret Murray

15. Birthplace Baltimore

16 (a) Informant Mrs V. Lippold

(b) Address 2904 Ecclston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)

(c) Cemetery or crematory Catonsville

Location Old Frederick Rd

18 (a) Funeral director J. J. Doley & Sons

(b) Address 218 Lafayette Ave.

19 (a) (b) Registrar Washington Williams M.D. Registrar

JUN 11 1945

VS 45

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to

Other Conditions Mental Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6/9/45 at 12:45 A.M.

(b) Where did injury occur? 3230 Presstman St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Hanged self w rope

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed June 10 1945

(over)

N. B.—WRITE PLAINLY, WITH UNFADING INK—This IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29685 G29685

CERTIFICATE OF DEATH

83a Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 N. Rose St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ...yrs. 8 mos. 27 ds. How long in U. S. If of foreign birth? ...yrs. ...mos. ...ds.

2. FULL NAME Edana N. Zimmerman If U. S. Veteran specify WAR

(a) Residence: No. 1920 N. Rose St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edward R. Zimmerman

6. DATE OF BIRTH (month, day, year) March 3, 1869

7. AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
76.	3	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 11

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carroll Co Md.

FATHER

13. NAME Henry Bankard

14. BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland

MOTHER

15. MAIDEN NAME Mary A. Reed

16. BIRTHPLACE (city or town) (State or country) Carroll Co Maryland.

17. INFORMANT Mrs. Nannie B. Souder (Address) 1926 Edgewood Road Govans Baltimore, Md.

18. BURIAL, CREMATION, OR REMOVAL Place London Park Date 6-12-1945

19. UNDERTAKER Loring-Ingers (Address) 2005 Park Heights Ave.

20. FILED ...19... Registrar.

JUN 11 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 6-9, 1945

22. I HEREBY CERTIFY, That I attended deceased from April 20 1945 to June 9 1945

That I last saw her alive on 6-9 1945. Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
ARTERIOSCLEROSIS	15 YRS
HYPERTENSION	10 YRS

Other contributory causes of importance:

CEREBRAL HEMORRHAGE	10 DAYS

Was an operation performed? ...Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ...Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ...Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) James J. Carmody M.D. M. D.

(Address) 3378 Mt. Holly St

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G29686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 D

G29686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Cathedral St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1130 Cathedral St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie E. Shockley

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: [redacted]

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 1916

8. AGE: Years 28 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business Wallace Gilbert Co

FATHER
12. Name George Shuy
13. Birthplace Md

MOTHER
14. Maiden Name Marie Wolker
15. Birthplace Md

16 (a) Informant Wm R Shockley
(b) Address 1130 Cathedral St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 2? St. Paul st.

JUN 12 1945

19 (a) (b) (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to June 10 1945, and that I last saw her alive on June 9 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. W. Jacobs M. D.
Address 2310 Eutaw Place Date signed 6-11-45

X Jacobs

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G29687 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Oliver Sts.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3911 Fleetwood Ave.
(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elsie Coole.

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maxwell E. Coole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/87

8. AGE: Years 57 | Months 7 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris Schmidt

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Mueller

15. Birthplace Germany

16 (a) Informant Maxwell Coole

(b) Address 3911 Fleetwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location Parkville Md.

18 (a) Funeral director Milhous Coole Inc

(b) Address 1214 E. Fayette St.

19 (a) ... (b) Henrietta for Williams, M.R. Registrar

JUN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/ 1945, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1945 to 6/10 1945, and that I last saw her alive on 6/10 1945

Immediate cause of death Ruptured Aneurism

Due to C. V. Accident

Due to Hypertension.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John T. Cassedy M. D.

Address St. Jos. Hosp. Date signed 6/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. G29688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4216 Kolb Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 Kolb Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Ernest Rahn

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 213-05-3415
4 Sex: Male
5 Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Margaret E.
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) Oct 14, 1886
8. AGE: Years 58 | Months 7 | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business

FATHER
12. Name Henry W.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jennie Yingling
15. Birthplace Westminster Md

16 (a) Informant Margaret E. Rahn (Wife)
(b) Address 4216 Kolb Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JUN 12 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 10 1945 and that I last saw him alive on June 10 1945.

Immediate cause of death: Coronary Thrombosis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret E. Rahn

Address 1735 Poplar Rd Date signed 6/14/45

VS 150

G29689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29689 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter O Duvall

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none
4 Sex: Male
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 11 1896
8. AGE: Years 68 Months 9 Days 29 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Handyman
11. Industry or business Self

FATHER
12. Name George W Duvall
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary B. K Phillips
15. Birthplace Baltimore Md

16 (a) Informant Ormsby D Hampson
(b) Address 6101 Smithurst Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Wilhelm Co Inc
(b) Address 1219 E Fayette St
19 (a) Date received (b) Huntington Williams, M.D. Registrar

JUN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to May 1945 and that I last saw h[illegible] alive on May 16 1945

Immediate cause of death: Angina Pectoris or Coronary Thrombosis (Sudden death)
Due to: Hypertension Arteriosclerotic Heart Disease with
Due to: Auricular Fibrillation
Other Conditions: Cerebral Arteriosclerosis (Slight stroke 6 months ago)
(Include pregnancy within 3 months of death)

Duration
Momentary
Several years
years
years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert W. Faris M. D.
Address 1017 St. Paul St Date signed 6/11/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 629690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Bookes
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years	Months	Days	If less than one day
3			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Capt. Arthur P. Anderson
13. Birthplace Penna.

MOTHER
14. Maiden Name Evelyn Crowther
15. Birthplace Md.

16 (a) Informant Evelyn Anderson
(b) Address Bookes, md.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)

(c) Cemetery or crematory Mazerine memorial
Location Bel Air md

18 (a) Funeral director Wantz Eckrich
(b) Address Jarrettsville md

JUN 12 1945
(Date rec'd by registrar)

19 (a) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1945, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1945 to 6/11 1945, and that I last saw him alive on 6/11 1945

Immediate cause of death	Duration
Acute Dilatation of Heart	
Due to Pulmonary Edema	
Due to	
Other Conditions Bronchopneumonia, Fatal Cerebral Edema	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operations: None
of autopsy: Dilated Heart, Bronchopneumonia, Cerebral Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Moorby Jr. M. D.
Address Univ Hosp Date signed 6/11

VS 150

G29691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G29691

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W. Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. McGraw

3 (b) If veteran, name war: no.

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: separated

6 (b) Name of husband or wife: Etta Mc. Graw

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb 27. 1884

8. AGE: Years 61 | Months 3 | Days 14 | If less than one day: hr. min.

9. Birthplace Beckley, W. Va.
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name James N. Mc. Graw
13. Birthplace Fr. Va.

MOTHER
14. Maiden Name Pauline Mc. Ginnis
15. Birthplace W. Va.

16 (a) Informant Oscar R. Mc. Graw
(b) Address 213 W. Mosher St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 12. 1945 (month) (day) (year)

(c) Cemetery or crematory Pine Grove
Location Beckley W. Va.

18 (a) Funeral director Mrs. Mrs. John N. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) Date received by local registrar JUN 12 1945 (b) Huntington West Virginia, M.F.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1945 to 6/10 1945, and that I last saw him alive on 6/10 1945.

Immediate cause of death: Probable Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles E. Shaw, M.D.
Address Md. Gen'l. Hosp'l. Date signed 6/11/45
M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: D.O.A. Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Stockton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie J. Ray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or ~~wife~~ Harrison Ray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 2, 1887

8. AGE: Years 58 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Robert Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Grace Jones
15. Birthplace Md.

16 (a) Informant Dorothy Ray (daughter)
(b) Address 1106 N. Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus Balto. Co. Md.

18 (a) Funeral director John M. Johnson
(b) Address 1700 Druid Hill Ave

19 JUN 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945, at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCalley M.D. Medical Examiner.
Date signed 6/10/45.

G29693 ✓ G29693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 N. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS EDWARD CALLAN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-09-2899

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Grace Callan

6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Dec. 23. 1873

8. AGE: Years 71 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Brass Molder

11. Industry or business

FATHER
12. Name: Peter Callan
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary Clockerty
15. Birthplace: Ireland

16 (a) Informant: Mr. Gilbert Keller
(b) Address: 948 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 1945 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: North Ave. & Broadway

JUN 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945 at 3.18 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from aug 10 1944 to June 10 1945, and that I last saw h[illegible] alive on June 9 1945.

Immediate cause of death	Duration
Bronchus Pneumonia	5 d.
Due to Chronic Nephritis	10 mo
Due to Chronic Interstitial Nephritis	10 mo
Other Conditions	10 mo

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Fa Stevens M. D.
Address 2878 Harford Rd Date signed 6-10 45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-76161 G29694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G29694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs- 9mos-23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Boston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Emory

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18- 1879

8. AGE: Years	Months	Days	If less than one day
66	0	19	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name William Emory
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Overdict
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof JUNE 12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Selby & Sons
(b) Address 403 S. WOLFE ST.

19 (a) (b) Registrar
(Date received by Registrar)
JUN 12 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7- 1945, at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1942, to 6-7- 1945, and that I last saw h im alive on 6-7 1945.

Immediate cause of death Bronchopneumonia
Bronchestasis

Duration ? yrs

Due to Carcinoma of Colon

Due to

Other Conditions Embolism
Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Date signed 6-11-45 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Cedardale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Cedardale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard J. M. Reinhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife Mary E. Mosher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Manufacturer.
11. Industry or business

FATHER
12. Name Henry J.
13. Birthplace Ger.

MOTHER
14. Maiden Name Mary E. ?
15. Birthplace Ger.

16 (a) Informant Family
(b) Address 3401 Cedardale Rd.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director J. L. McCaul
(b) Address 23 E. Thuntington Williams, M.D.

19 (a) JUN 12 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945, at 1:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to June 9 1945, and that I last saw h-- alive on June 8 19

Immediate cause of death Cerebral hemorrhage and paralysis — Duration 4 days
Due to
Due to Advanced arteriosclerosis ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or ~~homicide~~
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur ~~about home, on farm, industrial place~~, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Wellington Dublett M. D.
Address 2220 Garrison Date signed June 11/45 - Dlvet X

G29696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

F35

Registered No. G29696

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 BERWYN AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 41 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 BERWYN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida Weinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel Weinstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hyman Nathanson
13. Birthplace Russia

MOTHER
14. Maiden Name Bertha -
15. Birthplace Russia

16 (a) Informant Samuel Weinstein
(b) Address 3509 Berwyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-45 (month) (day) (year)
(c) Cemetery or crematory Beth Israel Cem.
Location Windsor Mill Road

18 (a) Funeral director Jack Kevra Inc.,
(b) Address 1439 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150 JUN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10-45 19 at 5 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 42 to June 2 1945, and that I last saw h.W. alive on June 9 1945.

Immediate cause of death: myocardial failure — Duration: 2 yrs

Due to: Hypertension — 6 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1720 Eutaw Pl Date signed 6/10/45

X

G29697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

P 3 B G29697 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 No Pulaske St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 No Pulaske St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Hyghstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Celia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs. Irvin Stein
(b) Address 1909 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-45 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location

18 (a) Funeral director Joe Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

JUN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11- 1945, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1945 to June 11 1945 and that I last saw h alive on June 11 1945

Immediate cause of death: Cerebral Thrombosis — Duration 4½ months
Due to: Arteriosclerosis — Duration ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip J. Levin, M.D.
Address 2461 N. Howard Ave. Date signed 6/13/45

G29698 G29698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 ELLAMONT ST
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3734 Winterbourne Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SOPHIA KEMPNER NYE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife ALEXANDER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 4, 1867

8. AGE: Years 77 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name LEON HARTMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name THERESE H. LOWMAN
15. Birthplace GERMANY

16 (a) Informant DR. SAM WOLMAN
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-13-45 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date received by Registrar) (b) A. Huntington Williams, M.D. Registrar

JUN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11- 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to June 11 1945 and that I last saw h[illegible] alive on June 11 19 45

Immediate cause of death Arteriosclerotic Cardio-renal disease — Duration 10 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sam'l Wolman M. D.

Address 2424 Eutaw Pl. Date signed June 11 45

X

G29699

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29699

CERTIFICATE OF DEATH 33B

Registered No. 29699

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Fred. Co.
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. 6th St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Terriann Abrecht
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER 12. Name Robert A. Abrecht
13. Birthplace Md
MOTHER 14. Maiden Name Lauren Foreman
15 Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet Cemetery
Location Frederick - Md.

18 (a) Funeral director C. E. Clise & Son
(b) Address Frederick - Md.

19 JUN 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945 at 1 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1945 to June 12 1945 and that I last saw her alive on June 12 1945

Immediate cause of death	Duration
Influenza & Pneumonia	6 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey C. Manelly M. D.
Address H.A. Date signed 6-12-45

X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2449 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2449 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE E. SIEMERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George C. Siemers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1856

8. AGE: Years	Months	Days	If less than one day
88	6	6	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Carol Mattfeldt
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Weber
15. Birthplace Germany

16 (a) Informant Miss Rita M. Siemers
(b) Address 2449 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Huntington Williams M.D.

19 (a) JUN 12 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945, at 5:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to June 10 1945, and that I last saw h[illegible] alive on June 9 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1½ h.
Due to	
Due to Coronary Sclerosis	about 3 years
Other Conditions Old Age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. G. Mertz M. D.
Address 716 Cathedral Date signed 6-11-45

VS 190

G29701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B [illegible] Registered No. 14685

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 26da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 Oakcrest Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
[illegible], Herbert Evans White

3 (b) If veteran, name war	3 (c) Social Security Account No.
Vet.W.War I.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marcilean Whitaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1897

8. AGE: Years	Months	Days	If less than one day
47	6	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Auditor - C. P. A.
11. Industry or business H. L. Langrall & Co.

FATHER
12. Name Horace White
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mattie Agner
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marcilean W. White
(b) Address 3027 Oakcrest Ave.

17 (a) Burial (b) Date thereof 6/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 19 1945 (b) Huntington Whitaker
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, 6:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1945, to June 11 1945, and that I last saw him alive on June 11 1945.

	Duration
Immediate cause of death Hodgkins Disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
U.S.Marine Hospital Date signed 6/11/45

G29702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. G29702

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. Hanover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles G Judy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10. 1892

8. AGE: Years 53 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace West Va (Town, county, and state)

10. Usual Occupation Type Fitter Helper

11. Industry or business Distillery Steel

FATHER
12. Name Mc Celony Judy
13. Birthplace W Va

MOTHER
14. Maiden Name Anna Smathers
15. Birthplace W Va.

16 (a) Informant Mrs Martha Judy
(b) Address 719 S Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location R C Cem

18 (a) Funeral director Fallon Bros Inc
(b) Address 2147 Pont St

19 JUN 12 1945 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945 at 6 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating gas.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/10/1945 5:20 A. M.
(b) Where did injury occur? 718 Hanover St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Found c gas hose in mouth.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 10 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G29703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Mc Elderry ch
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 McElderry Ch
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Shirley Ann Hardnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1933

8. AGE: Years	Months	Days	If less than one day
12			hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Hardnett
13. Birthplace N. C.

MOTHER
14. Maiden Name Rosetta Robinson
15. Birthplace N. C.

16 (a) Informant Rosetta Robinson
(b) Address 1204 Mc Elderry Ch

17 (a) Burial (b) Date thereof 6/12/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenville
Location Greenville, N. C.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pierpont St

19 JUN 12 1945 (b) Huntington Williams, M.D.
(Signature and title)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 10 1945, and that I last saw h[illegible] alive on June 10 1945.

Immediate cause of death	Duration
	1 yr.
Due to Metastatic carcinoma of lungs.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Barnwell M. D.
Address [illegible] Date signed 12 June

G29704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29704 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flint St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Mt. Holly St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George August Tschudy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1862

8. AGE: Years	Months	Days	If less than one day
82	7	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business C & P

FATHER
12. Name Ernest V Tschudy
13. Birthplace France

MOTHER
14. Maiden Name Marie Bertrain
15. Birthplace France

16 (a) Informant Mrs Anna McGee
(b) Address 2100 Mt Holly St

17 (a) Burial (b) Date thereof June 14, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) JUN 12 1945 (b)
(Date received by local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 11 20 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L Graham M.D.
Medical Examiner.
Date signed June 11 1945

G29705 | BALTIMORE CITY HEALTH DEPARTMENT | G29705

CERTIFICATE OF DEATH 123

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 S. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Stokowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-12-0392

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1883

8. AGE: Years 57 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Poland. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Stokowski
13. Birthplace Poland.

MOTHER 14. Maiden Name Mary. 2 c
15. Birthplace Poland.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 14 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Location Baltimore Catholic

18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS No. JUN 12 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 11 1945, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June - 10 1945, to June - 11 1945, and that I last saw him alive on June - 11 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Peritonitis	
Due to Perforation of recto-sigmoid	
Other Conditions Aspiration Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation June 10, 1945

Major findings of operation: Laceration of recto-sigmoid 2 cm. long

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard F. Kuffa, M.D.
Address John Hopkins Hosp. Date signed 6-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Penrose Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1943 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles G. Steems

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Amos Steems

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 14 1896

8. AGE: Years 48 Months 5 Days 27 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Rel Keeper

11. Industry or business Self

FATHER
12. Name Charles F. Steems
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary E. Krieb
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Genevieve A. Wortman
(b) Address 2228 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Gowan & Son
(b) Address 2001 Gallows St.

19 (a) (Date rec'd by registrar) JUN 12 1945 (b) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945, to June 10 1945, and that I last saw h alive on 19

Immediate cause of death: Cerebral sclerosis

Due to: Hypertension

Due to: Cardio Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Calaphonia Date signed 6/14/45

X Samuel Rubin

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G29707

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1527 Lovington

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1527 Lovington (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Katharine Holmes

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer Holmes

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) July 15, 1880

8. AGE: Years 64 | Months 10 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER — 12. Name John G. Wagner

13. Birthplace Germany

MOTHER — 14. Maiden Name Katharine

15. Birthplace Germany

16 (a) Informant Miss Edith Holmes

(b) Address 1527 Lovington Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director A. Howard Evans

(b) Address 1400 N. Charles St

19 (a) ..... (b) Huntington Williams, M.D. Registrar

(Date received by Registrar) JUN 12 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to June 11 1945 and that I last saw h-r alive on 6-11 1945

Immediate cause of death: Chronic Myocardial Degeneration — Duration: 1 yr.

Due to Arteriosclerosis — 1 yr.

Due to Diabetes Mellitus — 2 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. L. Sellod M.D.

Address 707 Fortlive. Date signed 6-12-45

G29708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G29708 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11, 1927

8. AGE: Years 18 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Md.

16 (a) Informant Mary Brown
(b) Address 417 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Ebon O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

JUN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 12 M. 15

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/7/45 at 12 midnight M.
(b) Where did injury occur? In front 404 N. Durham St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Sharp Instrument

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 6-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29709 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Monument Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto city

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2622 Ridgely St (If rural give location)

(e) Citizen of foreign country? Not (Yes or No)

If yes, name country

3 (a) FULL NAME John Newkirk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race B

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant FANNIE NEWKIRK

(b) Address 2622 Ridgeley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Elroy A. Wilson 1000 Gilmor St Baltimore

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1945, to June 9 1945, and that I last saw h[illegible] alive on June 9 1945.

Immediate cause of death	Duration
(a) Congestive failure	5 months
Due to Arteriosclerotic cardiovascular disease	?
Due to Arteriosclerosis	?
Other Conditions Hydrocephalus	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. V. Palmer M. D.

Address University Hospital Date signed 6/10/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29710 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Gorham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Bl. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 15 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md (City, county and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Robert Gorham
13. Birthplace N. C.

MOTHER
14. Maiden Name Lizzie Tillany
15. Birthplace N. C.

16 (a) Informant Rosa Pinder
(b) Address 1137 W Saratoga

17 (a) Burial (b) Date thereof 6/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury ave

19 (a) (Date rec'd by registrar) (b) Registrar

UN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1945, to 6-9 1945, and that I last saw him alive on 6-9 1945

Immediate cause of death Tuberculous peritonitis — Duration

Due to

Due to

Other Conditions Pulmonary tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto R. Ewing, M.d.

Address Univ. Hosp.; Balto, Md. Date signed 6/11/45

Huntington Williams, M.D.

G29711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G29711
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 A Matthew St. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country 1421 St.

3 (a) FULL NAME Fred Hancock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-28

8. AGE: Years	Months	Days	If less than one day
16	8	8	hr. min.

9. Birthplace Lynchburg / Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fred Hancock
13. Birthplace Va

MOTHER
14. Maiden Name Carrie Watts
15. Birthplace Va.

16 (a) Informant Carrie Hancock
(b) Address 1421 St. Matthews

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Braddish Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 1 1945

VS-151

MEDICAL CERTIFICATION 36

20. DATE OF DEATH June 10, 1945, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8 P.M. at 6-10-45 M.
(b) Where did injury occur? Lying in gutter in front of 108 Aisquith St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 6-11-45

G29712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G29712 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marjorie Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-31

8. AGE: Years	Months	Days	If less than one day
13	8	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Walker Hood
13. Birthplace NC.

MOTHER
14. Maiden Name Hannah Helen Harris
15. Birthplace S C.

16 (a) Informant Hannah Helen Hood
(b) Address 612 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9-45 19 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31- 1945 to 6-9- 1945 and that I last saw her alive on 6-9- 1945

Immediate cause of death Carcinoma of Rectum

Due to T. B. of Brain

Due to Tuberculosis of Lungs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Hansman, M.D.
M. D.

Address 2340 Madison Ave. Date signed 6-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29713 Kipp

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 O'Donnell
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Frederick Kipp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: widower

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/2/1870

8. AGE: Years 65 | Months 1 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bldg. Superintendent

11. Industry or business

FATHER
12. Name John Kipp
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Canoles
15. Birthplace Germany

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (To be filled in by registrar) (b) Huntington Williams, M.D. Registrar

JUN 12 1945
VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 7 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1945 to 6-11 1945, and that I last saw him alive on 6-11 1945.

Immediate cause of death: Pulmonary embolus — Duration

Due to: Thrombophlebitis

Due to:

Other Conditions: Hypertension, arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Little, M.D.
Address Church Home & Hosp. Date signed 6-11-45

100 B

G29714 BALTIMORE CITY HEALTH DEPARTMENT G29714
Registered No.

CERTIFICATE OF DEATH 469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 E.Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 E.Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F.MacLeod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Nettie Orrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.31,1868

8. AGE: Years	Months	Days	If less than one day
76	5	10	hr. min.

9. Birthplace A.A.Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Donald
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Martha Smith
15. Birthplace A. A. Co.

16 (a) Informant Mary E. S. MacLeod
(b) Address 1600 E. lanvale St.

17 (a) Burial (b) Date thereof 6/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 JUN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/45 19 , at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to June 10 1945, and that I last saw alive on June 12 1945.

Immediate cause of death Carcinoma of Pancreas — Duration 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Strong M. D.
Address 028 Lanvale Date signed 6-11-45

X

G29715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G29715 Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D & A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 119 Ritchie Hgy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wengert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	D

6 (b) Name of husband or wife Ida M. Weaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 12, 1888

8. AGE: Years	Months	Days	If less than one day
57	2	29	hr. min.

9. Birthplace A.A.CO Md. (Town, county, and state)

10. Usual Occupation Mch. Balto. D.D.

11. Industry or business

FATHER
12. Name not known
13. Birthplace A.A.CO. Md.

MOTHER
14. Maiden Name not known
15. Birthplace A.A.Co. Md.

16 (a) Informant Marjorie Emsenat
(b) Address 1710 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director Lafayette F. Hoffman
(b) Address 16 S. Broadway

19 (a) JUN 12 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945 at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 6-11-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29716
AB-79124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G29716
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yr-4mos-29 days
(e) Length of stay in Baltimore (yrs., mos., or days) ??yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Dimmling Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susanna Muller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3-? (84?

8. AGE: Years	Months	Days	If less than one day
84 ?	2	8	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Buchert
13. Birthplace Germany

MOTHER
14. Maiden Name Adeline Daub
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13-45 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Donnell St.

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) JUN 12 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11- 1945 at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12- 1943 to 6-11- 1945
and that I last saw h... alive on 6-11- 1945
Immediate cause of death Bronchopneumonia — Duration 8 days
Due to
Due to
Other Conditions Senile Arteriosclerosis
Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. M. Cliff M. D.
Address Bryant & Hoff Date signed 6/11/45

C29717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C29712

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4515 Garrison Boulevard

(c) Hospital or institution: 15 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----

(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County -------

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4515 Garrison Boulevard
(If rural give location)

(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Annie J. Buchanan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. B. Buchanan

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------

8. AGE: Years	Months	Days	If less than one day
About 70	---	---	-- hr. --- min.

9. Birthplace West Brady, Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business -------

FATHER
12. Name Robert Wallace
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Adda Newlon
15. Birthplace Not obtainable

16 (a) Informant William B. Buchanan
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof 6/13/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location East Brady, Pa.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert St.

19 JUN 12 1945 (b) Huntington Williams Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1945, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1945 to 6/10 1945 and that I last saw her alive on 6/10 1945

Immediate cause of death Cerebral arterio sclerosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Arthur W Kac M. D.

Address 3862 Dolfield Date signed 6/12/45

X Cane

VS 150

G29718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No. G29718

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 23 S Calvert Rd

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D-4

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 23 S. Calvert Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Ida May Latham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jos. L. Latham

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 25, 1880

8. AGE: Years 65 | Months 2 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER 12. Name Harry Watson

13. Birthplace New Jersey

MOTHER 14. Maiden Name Emily Hoover

15. Birthplace Baltimore Md.

16 (a) Informant Jos. L. Latham

(b) Address 23 S. Calvert Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-40 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Fayette Ave

18 (a) Funeral director Thos J Kenny

(b) Address Holliday & Eutaw

19 JUN 12 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9. 1940 at 6.42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940 to June 9 1940 and that I last saw h[illegible] alive on June 9 1940.

Immediate cause of death	Duration
Coronary Thrombosis	1 yr.
Due to Arterial Sclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Chas A Carter M.D.

Address 2145 W Balto Date signed 6/11/40

VS 150

X

G29719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29719 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1357 Hull St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 Hull St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul. Krupinski

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Frances. Krupinski

6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1865

8. AGE: Years 80 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace: Poland
(town, county, and state)

10. Usual Occupation: Stevedore

11. Industry or business

FATHER
12. Name: Unknown.
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Stella Wojcik
(b) Address: 1357 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/1945 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross Cem.
Location: Annapolis Blvd.

18 (a) Funeral director: Chas F. Kirk
(b) Address: 1506 E. Fat Ave

19 (a) JUN 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1944, to June 10, 1945, and that I last saw living alive on June 10, 1945.

	Duration
Immediate cause of death: Chronic Myocardial Degeneration	2 yrs.
Due to: Arteriosclerosis	3 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: A. Sullod

Address: 707 Fort Ave. Date signed: 6-M 12-D 45

G29720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V124a

G29720 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs. 45 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Brookfield #17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Vivian Zeller Zeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Robert Carl Zeller

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1910

8. AGE: Years	Months	Days	If less than one day
34	9	14	hr. min.

9. Birthplace Columbus, Ohio
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ira B. Pressler
13. Birthplace Ohio

MOTHER
14. Maiden Name Antoinette ——
15. Birthplace ?

16 (a) Informant Husband
(b) Address 2109 Brookfield #17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-45 (month) (day) (year)
(c) Cemetery or crematory Columbus Ohio
Location Ohio

18 (a) Funeral director Chas. F. Diehl
(b) Address 1521 E. Fort Ave.

19 (a) JUN 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 11 1945, and that I last saw her alive on June 11 1945.

Immediate cause of death Fatty degeneration of Liver — Duration

Due to Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Fatty degeneration of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. McCormack M. D.
Address Date signed

Rec'd in Frstr mail

G29721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G29721
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 875 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jones Ollie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Annie L Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-1901

8. AGE: Years 44 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George H. Jones.
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Martha
15. Birthplace Somerset Co. Md.

16 (a) Informant Annie Jones
(b) Address 875 W. Fairmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Winans - Md

18 (a) Funeral director Wm. Katie R. Williams
(b) Address 327 N. Belnord Ave.

19 (a) [illegible] (Registered by registrar) 6-12-1945 Huntington Mills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945 at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1945 to 6/9 1945 and that I last saw h~~im~~ alive on 6/9 1945

Immediate cause of death Pulmonary edema

Due to Metastatic C. of Lung & heart failure

Due to Cerebral metastasis

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. F. Cowley MD

Address Univ. Hosp. Baltimore Md. Date signed 6/10/45

R. F. Cowley X

G29722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104 B

G29722 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132 N. Gilmor St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Muriel Lane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Columbus Lane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1915

8. AGE: Years 30 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lemuel Lewis

13. Birthplace Matthews Va

MOTHER 14. Maiden Name Mary Smith

15. Birthplace Matthews Va

16 (a) Informant Miss Josella Lewis (Sister)

(b) Address Newport News Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof June 13/45 (month) (day) (year)

(c) Cemetery or crematory Church Cemetery

Location Matthews Va

18 (a) Funeral director Va Brooks

(b) Address 1463 N. Carey St

(c) (Signature of registrar) Huntington Williams, M.D.

JUN 12 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1945, to 6-9- 1945 and that I last saw h[illegible] alive on 6-9- 1945.

Immediate cause of death Cardiac Dilatation, Chron Gastric Infection, Stomach — Duration: Hours

Due to

Due to Poly arthritis

Other Conditions Appendicitis, Nasal Polyp arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 1135 Edmon Date signed 6/12/45

X

G29723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G29723 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Gill Linden Hall
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Silas Ferdinand J St Pierre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14-1865

8. AGE: Years 80 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Belgium (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ferdinand Vandenheede

13. Birthplace

MOTHER 14. Maiden Name Justine Baldwyck

15. Birthplace

16 (a) Informant Gill Linden Hall

(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

19 (a) (b) Filed by registrar Huntington Williams, M.D.

JUN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to June 11 1945, and that I last saw him alive on June 11 1945.

Immediate cause of death Intestinal Obstruction — Duration 5 days

Due to Carcinoma of Caecum — 1 yr.

Due to

Other Conditions Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Ave Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 182

G29724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Homewood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Catherine Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-1657

4. Sex W- F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/77

8. AGE: Years	Months	Days	If less than one day
67	7	28	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Clerk Balto Life Ins. Co.

FATHER
12. Name Michael Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Ann Duffy (Duffy)
15. Birthplace Ireland

16 (a) Informant Mrs. Farrell
(b) Address 1215 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Bilz Wredefeld
(b) Address 914 Greenmount Ave

19 (a) Huntington Williams Registrar (Date rec'd by registrar)
JUN 12 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 12, 1945, at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7/ 1945 to 6/12/ 1945, and that I last saw her alive on 6/12/ 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremic Toxemia (terminal)	
Due to Lesion of Spinal Cord and cerebrovascular hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Cavanaugh
Address St. Joseph's Hospital Date signed 6/12/45

X

G29725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

Registered No. G29725

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Henry Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BROOKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Route Collector

11. Industry or business Hospital

FATHER 12. Name Samuel Brookin

13. Birthplace Va

MOTHER 14. Maiden Name Mary

15. Birthplace Va

16 (a) Informant Margaret Taylor

(b) Address 105 N Isabella St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co Md

18 (a) Funeral director Isaiah L Brown & Co

(b) Address 108 W Montgomery St

19 JUN 13 1945 (b) Huntington Williams, Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945 at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an INSPECTION & Autopsy thereon, and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-10-45 at 1:05 P. M.
(b) Where did injury occur? Univ. Hosp. Lombard & Greene Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Caught in elevator-shaft between 2nd & 3rd floor

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed June 11 1945

G29726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-72051

Registered No. G29726

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 3- 15
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 Henrietta Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Payson Spruill or Pasaon Spruill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1908

8. AGE: Years	Months	Days	If less than one day
37	3	9	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jake Spruill
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Sykes
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Monfull?
Location Va

18 (a) Funeral director David L Brown & Son
(b) Address 1618 W Montgomery St

19 (a) JUN 13 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 45, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 19 42, to June 10 19 45, and that I last saw h im alive on June 10 19 45

Immediate cause of death	Duration
Pulmonary Tuberculosis	yrs
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: dr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo Edmund M. D.
Address City Hospitals Balto. Md. Date signed 6/15/45

G29727 ✓ G29727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene St

(c) Hospital or institution: University Hospital 8 1/4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore Edmondson (If outside city or town limits, write RURAL and give town)

(d) Street No. 3322 Easterly ave (If rural give location)

(e) Citizen of foreign country? no, (Yes or No)

If yes, name country

3 (a) **FULL NAME** Leo S. Connore.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife Maria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1873

8. AGE: Years 51 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name ? Connor

13. Birthplace Baltimore Co Md

MOTHER

14. Maiden Name Sarah Kelley

15. Birthplace Baltimore Md

16 (a) Informant Maria Connor

(b) Address 3322 Easterly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director John C. Nolan

(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS JUN 13 1945 Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1945, at 11:07 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2- 1945, to 6-10- 1945, and that I last saw him alive on 6-10 1945.

Immediate cause of death Generated Gastric ulcer Perforated

Due to Peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-4-45

Major findings of operation Perforated Gastric ulcer

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D.W. Mentzer M. D.

Address Univ. Hosp. Date signed 6-10-45

X

G29728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G29725 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 E 37th St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 E 37th St (If rural, give location)
(e) Citizen of foreign country? 37 (Yes or No) If yes, name country

3 (a) FULL NAME Florence H. McGarity

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Bernard J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1875

8. AGE: Years 69 | Months 6 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Joseph D. Calbert
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Charlet A. Flaherty
15. Birthplace Baltimore Md

16 (a) Informant Bernard J. McGarity
(b) Address 703 E 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John G Moran
(b) Address 3000 E Baltimore St

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams 722 N. Howard

VS 150 JUN 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 8:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to June 11 1945, and that I last saw her alive on 6/10/1945

Immediate cause of death: Cerebral Hemorrhage — Duration 6/5/45
Due to: arterio-sclerosis Hypertension —
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis H. Krumbein M. D.
722 N. Howard
Date signed 6/13/45

G29729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 Q

G29729 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Eubank
(c) Hospital or institution Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 W Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph Quade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 76

8. AGE: Years 68 | Months 10 | Days | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Anthony Quadel
13. Birthplace Italy

MOTHER
14. Maiden Name Not Available
15. Birthplace Italy

16 (a) Informant Dan'l L. Quadel
(b) Address 5000 Liberty Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 14 45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Gate Md

18 (a) Funeral director Geo. A. Farley
(b) Address Fulton & Fayette

19 (a) (b)

JUN 13 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 / 11 1945, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1945 to 6/11 1945 and that I last saw h[illegible] alive on 6/11 1945

Immediate cause of death	Duration
Congestive Heart Failure	14 days
Due to Coronary Thrombosis	?
Due to Generalized arteriosclerosis	
Other Conditions Cardiac asthma + Bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Strickel M. D.
Address Bon Secours Hosp. Date signed 6/11/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1Q

G29730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mickleand & Payson
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ###
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 N.Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Heidel

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-03-5210

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ethel M.Heidel

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Oct.1,1896

8. AGE: Years 48 | Months 8 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Material Checker

11. Industry or business Ship Yard

FATHER
12. Name Martin L.Heidel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs.Ethel M.Heidel
(b) Address 2014 N.Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14,1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W.Little
(b) Address 2700 Edmondson Ave.

19 (a) ..... (b) ..... (Signature of registrar)

JUN 13 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 11 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945, to June 11 1945, and that I last saw h im alive on June 11 1945.

Immediate cause of death Cardiac decelation

Due to Coronary thrombosis

Due to Hypertensive Cardio vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter Bell Baldwin M.D.

Address West Baltimore General Hospital 6/14/45

G29731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G29731

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County N
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 East Read St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kemp Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Rev. Elbert B. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Hammond
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine McCubbin
15. Birthplace Maryland

16 (a) Informant George Thomas
(b) Address 6 E. Read St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frd. Ave. Balto. Md.
18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

JUN 13 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 1 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to June 12 1945 and that I last saw her alive on June 12 1945

Immediate cause of death: Cardio-Resp. Failure
Due to: Cerebro-vascular Accident
Due to: Hypertension, essential
Due to: Generalized Arteriosclerosis
Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchizedek Spragins
Address U. M. H. Date signed 6-12-45 M.D.

VS 150

831

G29732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157

Registered No. G29732

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James D. Heinlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-45

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo. Heinlein
13. Birthplace Md.

MOTHER 14. Maiden Name Daisy Mill
15. Birthplace Md.

16 (a) Informant Geo. Heinlein
(b) Address 1646 N. Fulton Ave Balto

17 (a) Burial (b) Date thereof 6 15 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crisfield Cem
Location Crisfield Md

18 (a) Funeral director John A. Bradshaw Jr.
(b) Address Crisfield, Md

19 JUN 13 1945 Huntington Williams MR
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12/1945, at 10 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9/1945 to 6/12 1945 and that I last saw h[illegible] alive on 6/12 1945.

Immediate cause of death	Duration
General debilitation	
Due to Intussusception	
Due to	
Other Conditions Infant	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Ratliff A. M. D.
Address St. Agnes Hospital Date signed 6/13/45

G29733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B ✓

Registered No. G29733

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2050 Bank Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2050 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. Yes

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ wife: Anna P. Deceased

6 (c) If alive, give ~~address~~

7. Birth date of deceased (mo., day, yr.) 1886 ?

8. AGE: Years 59 ? | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Jacob Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Edward Wisniewski (Son)
(b) Address 2050 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director Geo. A. Weber
(b) Address 705 South Ann Street

19 (a) Date received JUN 13 1945 Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1945, at 11.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945, to June 12 1945, and that I last saw him alive on June 12 1945

Immediate cause of death: Broncho-Pneumonia — Duration: 6/10/45

Due to: Pulmonary Tuberculosis — ??

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 209 E. Chase St. Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Geelhaar

G29734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

Registered No. G29734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Hartford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Hartford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Geelhaar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Earnest Jr.

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.) May. 22, 1878

8. AGE: Years 67 | Months 2 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name George Sutton
13. Birthplace England

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Earnest J. Geelhaar
(b) Address 1138 Hartford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15 1945 (month) (day) (year)
(c) Cemetery or crematory Pale Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer Conklin Co.
(b) Address 924 E. Eager St.

19 JUN 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 19 45 at 1220 M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature S. LUBINSKI M.D. Medical Examiner.
Date signed 6/12/45

G29735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 G

Registered No. G29735

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8231 Bon Air Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Elizabeth Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-72

8. AGE: Years 72 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Colthrust
13. Birthplace Brit-

MOTHER
14. Maiden Name McIntee
15. Birthplace Canada

16 (a) Informant Richard
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill Cemetery
Location Gwynn Mills Md.

18 (a) Funeral director Elmer W. Conkling & Son
(b) Address 9242 Eager St.

JUN 13 1945
(Date received by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 11 1945 and that I last saw he alive on June 11 1945

Immediate cause of death: Cardiovascular failure — Duration

Due to: Post operative —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-10-45

Major findings of operation: Carcinoma of the head of the pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Burnett M.D.
Address J.H.H. Date signed 6-11-45

VS 150

G29736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

472388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/31B

G29736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David K Boney.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nellie S

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 7-18-1899

8. AGE: Years 45 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county and state)

10. Usual Occupation Office. blerk.

11. Industry or business

FATHER
12. Name Alfred A Boney
13. Birthplace Pa.

MOTHER
14. Maiden Name Amelia Rose.
15. Birthplace Pa.

16 (a) Informant Reconda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory West Laurel Hill
Location Philadelphia, Pa.

18 (a) Funeral director Wm. Tucker & Sons
(b) Address 1 Penn Ave, Butler, Md.

19 (a) JUN 13 1945 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH June-13 1945 at 1.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April-16 1945, to June-13 1945, and that I last saw him alive on June-13 1945

Immediate cause of death: UREMIA — Duration

Due to CHRONIC GLOMERULO-NEPHRITIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Dickson M.D.
Address Johns Hopkins Hospital Date signed 6/15/45

VS 150

G29737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29737 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Washtenw ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Washtenw ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Fandl FANDL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Frances Fandl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27 1881

8. AGE: Years	Months	Days	If less than one day
63	5	14 20	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Rd. Tailor
11. Industry or business Tailoring Business

FATHER
12. Name Mathew Fandl
13. Birthplace Hungarian

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Fandl
(b) Address 400 Washtenw ave

17 (a) Burial (b) Date thereof 6-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel Co. Md

18 (a) Funeral director Geo. J. Beyer Jr
Address 1517 Hollins St

19 (a) JUN 13 1945 (Huntington Williams, Mgr.)
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 5 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to June 11 1945, and that I last saw h[illegible] alive on June 9 19 45

Immediate cause of death Coronary Thrombosis — Duration —

Due to Coronary Sclerosis — about 2-3 yrs

Other Conditions Diabetes Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Mann M. D.
Address 116 Lafayette St Date signed 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G29738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Coates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1889

8. AGE: Years 55 56 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Augustus Ridgely
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Ile Plains, Va

16 (a) Informant Charles J. Coates
(b) Address 526 N. Hoffman St.

17 (a) Burial (b) Date thereof June 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laura M. Holland
Address 1631 Druid Hill Ave.

19 (a) JUN 13 1945 (b) Huntington Williams, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945, at 11 25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 1945, to 6/9 1945, and that I last saw her alive on 6/9 1945.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension - Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Howell, M. D.
Address Provident Hospital Date signed 6/12/45

VS 188

G29739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G29739

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3038 Clifton Park Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Clifton Park Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH R. ARMSTRONG

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Samuel H. Armstrong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	0	hr. min.

9. Birthplace Chester Co., Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown Rumsey
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant Dr. Thomas H. Caldwell
(b) Address 3038 Clifton Park Terr.

17 (a) Burial (b) Date thereof 6/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Hill

JUN 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945, at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944, to June 12 1945, and that I last saw h[illegible] alive on June 12 1945.

Immediate cause of death Pneumonia — Duration 1 day

Due to Metastasis of ovarian carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 1945

Major findings of operation: Ca. of Ovary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3400 Eduardo Rd Date signed 6/13/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

✓ G29740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway 91
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md. (b) County
(c) ~~City or town~~ ~~Street~~ 1716 N Wolfe Ave.
(If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ Baltimore - 13 - Md
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Heath

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 214-20-9418

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence Heath

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-1884

8. AGE: Years 60 | Months 8 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business —

FATHER
12. Name James Heath
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Potter
15. Birthplace Maryland

16 (a) Informant Harry Heath
(b) Address 1716 N Wolfe Ave, Balto - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location
18 (a) Funeral director Chilys Newingtons
(b) Address 2024 Orleans St

19 (a) (Signature) (b) Huntington Williams, Undertaker

JUN 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1945 to 6-12 1945, and that I last saw him alive on 6-12 1945.

Immediate cause of death	Duration
Uremia due to	
Pyelonephritis	
Due to Pyelitis	
Due to renal calculi	
Other Conditions Pyonephrosis; Hydroureter, Uremia	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy Pyelonephritis - Renal Calculi

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B Leuchtenberg M. D.
Address Church Home & Hosp Date signed 6-12-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G29741

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Coleman

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12/24/1890

8. AGE: Years 54 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace: Alabama (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknable
15. Birthplace

16 (a) Informant: Daisy Dare
(b) Address: 802 Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat.
Location: Md

18 (a) Funeral director: Geo. H. Kelson
(b) Address: 1303 Pleasant St

19 (a) (Date rec'd by registrar) (b) Registered: JUN 13 1945 Harlington Hardesty, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945, at 3-45 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert L. Gaither M.D. Medical Examiner.
Date signed June 12 1945

G29742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V54a

Registered No. G29742

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County .....
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 EVESHAM AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME
HERBERT F. BYRNS

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 063-07-3275

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: DOROTHY BYRNS
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7/9/98

8. AGE: Years 46 | Months 11 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Expediter
11. Industry or business Glen L. Martin Co

FATHER
12. Name FRANK BYRNS
13. Birthplace NEW YORK

MOTHER
14. Maiden Name MARTHA HOPEWELL
15. Birthplace CONNECTICUT

16 (a) Informant Dorthy Byrns
(b) Address 701 E. Evesham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Lynchburg Va
Location Lynchburg Va

18 (a) Funeral director Wilson & Dye
(b) Address 1217 E. Pratt St

19 (a) JUN 13 1945 (Date rec'd by registrar) (b) Huntingtown Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1945, at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1945, to 6/12 1945, and that I last saw him alive on 6/12 1945.

	Duration
Immediate cause of death BRAIN TUMOR (GLIOMA)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/8/45
Major findings of operation: BRAIN TUMOR AND CYST OF LEFT CEREBRAL HEMISPHERE
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Paul H. Hurd M. D.
Address Md. Gen. Hosp. Date signed 6/12/45

X

G29743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G29743

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Widowed

6 (b) Name of ~~husband or~~ wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26th 1874

8. AGE: Years	Months	Days	If less than one day
70	11	14	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name (Unknown) Rogers
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Gertrude Andrathy
(b) Address 2847 Lake Ave

17 (a) Burial (b) Date thereof 6/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St.

19 JUN 13 1945
(Date rec'd by registrar) Printing for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 19 46 at 1 40 P M

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. A. Sulimonetti M.D.
Medical Examiner.
Date signed 6/16/46

G29744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 P

Registered No. G29744

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Brighton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 Independence st
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C. Ringard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband William F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18th 1867

8. AGE: Years	Months	Days	If less than one day
77	10	23	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Jones Dampman
13. Birthplace md.

MOTHER
14. Maiden Name Sarah Ann Stout
15. Birthplace Fort Wayne, Ind.

16 (a) Informant William F. Ringard
(b) Address 2930 Independence st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)

(c) Cemetery or crematory Presbyterian
Location Govans

18 (a) Funeral director William Gork Inc
(b) Address 4317 St Paul

19 JUN 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11th 1945; at 2 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1944, to June 11 1945, and that I last saw h[illegible] alive on June 6 1945.

Immediate cause of death	Duration
Terminal Bronchopneumonia	3 days
Due to Carcinoma of bladder	1 year?
Due to	
Other Conditions Hydronephrosis (left) Diabetes mellitus, Cholelithiasis. (Include pregnancy within 3 months of death)	?

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 york Rd Date signed 6/12/45

G29745

CWK-93166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29745

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 1- 25
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Cecil Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27-1867

8. AGE: Years 77 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Joseph McCoy (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ? (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1307 St. Paul st.

19 JUN 13 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1945, to June 12 1945, and that I last saw him alive on June 12 1945.

Immediate cause of death: Pneumonia — Duration: 8 days

Due to: Generalized arteriosclerosis — ?

Due to: Benign Prostatic Hypertrophy — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/8/45

Major findings of operation: Markedly enlarged prostate

of autopsy: Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E J Penny M.D.

Address Baltimore City Hospitals Date signed 6/13/45

G29746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G29746 Registered No. (Green)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 N Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N Mount St (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country

3 (a) FULL NAME Mary E Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas Matthews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Exact date unknown

8. AGE: Years: about 80 | Months: — | Days: — | If less than one day: hr. min.

9. Birthplace Essex Co Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Caroline Everett
15. Birthplace unknown

16 (a) Informant Maud Adams Baker, Friend
(b) Address 413 N Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-'40 (month) (day) (year)
(c) Cemetery or crematory Int. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Wallis
(b) Address 322 N. Schroeder St

19 (a) (Date received by local registrar) (b) JUN 13 1945 * Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to June 10 1945 and that I last saw h[illegible] alive on June 9 1945

Immediate cause of death: Chronic Interstitial Nephritis — Duration: Couple yrs

Due to: Arteriosclerosis

Due to:

Other Conditions: Mental Insufficiency

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph A Yearney M.D.
Address 1429 Mc[illegible] Date signed 6/12/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1102

G29747 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Finney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fannie Church

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 - 1911

8. AGE: Years	Months	Days	If less than one day
34	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Fannie Finney
(b) Address 505 N. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-'45 (month) (day) (year)
(c) Cemetery or crematory Arlington memorial
Location

18 (a) Funeral director Mrs. Katie R. Walbin
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1945, at 12 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1945, to 6/11 1945, and that I last saw him alive on 6/11 1945.

Immediate cause of death	Duration
Malignant Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leroy Berry, M.D.
Address Provident Hospital Date signed 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29748 Registered No. 92a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maud E. Murray
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence Murray
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) — — 1994

8. AGE: Years 57 | Months — | Days 7 | If less than one day: hr. min.

9. Birthplace Hartford Co Md (town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Alexander Swann
13. Birthplace Hartford Co Md

MOTHER
14. Maiden Name Mary Jameson
15. Birthplace Hartford Co Md

16 (a) Informant Etta Swann
(b) Address 107 Adams St. Shellman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13 (month) (day) (year)
(c) Cemetery or crematory Steelton Pa.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 JUN 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945 at 8.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1945, to June 10 1945 and that I last saw h.. alive on June 10 1945.

Immediate cause of death: Pulmonary Edema — Duration
Due to: Chronic Endocarditis — Duration
Due to: Hypertension — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 N Carrollton Ave Date signed 6/12/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1382

G29749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Newkirk Street (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Cirico Dimitrio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 1899

8. AGE: Years 46 | Months 3 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Greece, Rhodes Island, Aegean Sea (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Dayas Kambouras LIVES

(b) Address 813 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-45 (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox

Location Baltimore, Md

18 (a) Funeral director Howard J. Courtney

(b) Address 21 W. 20th St.

19 (a) JUN 13 1945 (Date rec'd by registrar) Huntington Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1945, at 2:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Chronic pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Scarlett M.D. (Medical Examiner)

Date signed June 6 1945

G29750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29750 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 860 Vine St.
(c) Hospital or institution: — 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 860 Vine St. (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME George Tyler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Georgeanna
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 8. 1. 1880
8. AGE: Years 64 Months 10 Days 8 If less than one day — hr. — min.
9. Birthplace Onancock, Va (Town, county and state)
10. Usual Occupation Carpenter
11. Industry or business Individual

FATHER
12. Name George Tyler
13. Birthplace Virginia

MOTHER
14. Maiden Name Mitchell
15. Birthplace Virginia

16 (a) Informant Estrella Waynewright
(b) Address 1110 Sarah Anne St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore County Md

18 (a) Funeral director Charles S. Cooper
(b) Address 1200 Carrollton Ave

19 (a) JUN 13 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6. 9. 45 19 , at 6 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5. 26 1945 to 6. 9. 1945 and that I last saw him alive on 6. 9. 1945

	Duration
Immediate cause of death, Congestive heart failure	6. 8. 45
Due to Hypertensive heart Disease	5. 26 45
Due to	
Other Conditions right Hydrocele	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —
23. Signature James M Parr M. D.
Address 400 N. Carrollton Ave Date signed 6, 13, 45

X

G29751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G29751 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2139 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2139 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE HELENA von LOSSBERG

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Harry vonLossberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24, 1881

8. AGE: Years	Months	Days	If less than one day
64	2	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alonzo Ferdinand Jones
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Louise Schenkel
15. Birthplace Balto., Md.

16 (a) Informant Mr. Lewis von Lossberg
(b) Address 2139 Mt. Holly St.

17 (a) Burial (b) Date thereof 6/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 13 1945 (b) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 12, 1945, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945, to June 12 1945, that I last saw her alive on June 12 1945.

Immediate cause of death Acute Peritonitis — Duration 8 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. G. Lally M D
M. D.
Address 3517 Edmondson Date signed June 13 1945

Huntington Williams M.D.

VS 150

X

G29752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G29752 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 N. Mount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Mount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Goldie Hayes Mullen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Andrew Mullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1916

8. AGE: Years 28 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name James A Hayes

13. Birthplace Richmond. Va

MOTHER 14. Maiden Name Lillie B. Wesley

15. Birthplace Balto. Md

16 (a) Informant Andrew Mullen

(b) Address 516 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director James A Hayes

(b) Address 142 Ostend St

JUN 13 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to June 12 1945 and that I last saw h[illegible] alive on June 12 1945

Immediate cause of death Myelogenous Leukemia — Duration 2 yrs

Due to

Due to

Other Conditions Cardiac Decomp. — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jeff Banyard, M.D.

Address 844 N. Carey St Date signed 6/13/45

G29753 G29753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-6914

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business (Salesman)

FATHER 12. Name Sherman Hill

13. Birthplace North Carolina

MOTHER 14. Maiden Name Margrett Wise

15. Birthplace A. A. Co. Md

16 (a) Informant Bernetta Jones

(b) Address 1416 McElderry St

17 (a) Burial (b) Date thereof June 15-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location A. A. Co. Md

18 (a) Funeral director Pifut E Williams

(b) Address 1515 McElderry St

19 (a) (b)
(Date rec'd by registrar) (Registrar)

JUN 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1945, at 3 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hos. death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert C. Graham M.D.
Medical Examiner.

Date signed June 12 1945

X

G29754 BALTIMORE CITY HEALTH DEPARTMENT G29754

CERTIFICATE OF DEATH 480

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2859 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2859 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Catherine Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Shannon Patterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24 - 1911

8. AGE: Years 33 | Months 7 8 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name George Batt
13. Birthplace York. Pa.

MOTHER
14. Maiden Name Louise Hoffman
15. Birthplace Baltimore Md.

16 (a) Informant Shannon Patterson
(b) Address 2859 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15 - 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore

18 (a) Funeral director Manus Cook-Sayler
(b) Address 1600 W. North Ave

19 (a) JUN 13 1945 (Date Received by Registrar) Huntington Williams, M.D. (Registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 2-45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to June 12 1945, and that I last saw h[illegible] alive on June 11 1945.

Immediate cause of death Carcinoma breast. — Duration

Due to

Due to

Other Conditions Metastatic carcinoma Lung (Bilateral)
(Include pregnancy within 3 months of death)

Date of operation Thor Hysterectomy

Major findings of operations Carcinoma breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Shannon M.D.

Address 820 Medical Arts Bldg Date signed 6/13/45
M. D.

G29755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29755 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Agnes Hospital
(c) Hospital or institution: Kelkens & Caton Aves

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md (If outside city or town limits write RURAL and give town)
(d) Street No. Caton & Kelkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Loretta Larkin

3 (b) If veteran, name war —

3 (c) Social Security Account No. — — — — —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-1871

8. AGE: Years 73 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace — (town, county, and state)

10. Usual Occupation Sister of Charity

11. Industry or business —

FATHER 12. Name Thomas Larkin

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Holmes

15. Birthplace Ireland

16 (a) Informant Gertrude Schmidt

(b) Address 109 S. Monastery Ave. Balto. 29. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 6/14/45

(c) Cemetery or crematory Catholic

Location Baltimore

18 (a) Funeral director Martin Ogden & Sons

(b) Address 1827 W. North Ave.

19 (a) (Person who supplied information) (b) Address Huntington Williamsport, Md.

JUN 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12/45 19 . at 6.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1943 to 6/12 1945 and that I last saw h[illegible] alive on 6-12 1945.

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Boyson M. D.
Address St Agnes Hosp Date signed 5/12/45

G29756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29756
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Monen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months — | Days — | If less than one day ___ hr. ___ min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailoring Business
11. Industry or business

FATHER
12. Name Bernard Monen
13. Birthplace Russia

MOTHER
14. Maiden Name Judith —
15. Birthplace Russia

16 (a) Informant Mrs Ida Hinkin
(b) Address 215 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Pulaski Rd & Hamilton ave

18 (a) Funeral director A. J. Levinson & Bro
(b) Address 1126 W North ave

JUN 13 1945 (Date registered) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 7.16 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to June 13 1945
and that I last saw him alive on June 13 1945

Immediate cause of death: Coronary Thrombosis — Duration: 1 week
Due to
Due to
Other Conditions: Cardio-Renal Vascular Disease
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. Sanchin
Address 2154 W. North ave Date signed 6/13/45

VS 150

94a

G29757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29757 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lutindale
(c) Hospital or institution: Belvidere ave + Greenspring
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham De Baer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation merch

11. Industry or business

FATHER 12. Name Jacob De Baer
13. Birthplace Holland

MOTHER 14. Maiden Name Emma Cohen
15. Birthplace Germany

16 (a) Informant Mrs J. Rosenberg
(b) Address 5809 Slater Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 36 — Block E. Balto st

18 (a) Funeral director Sol Levinson + Bros
(b) Address 1124-26 W. North ave

19 (a) 1945 (b) Registered by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 7.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1945 to 6-13 1945, and that I last saw h[im] alive on 6-13 1945.

Immediate cause of death: Right central hemiplegia
Hypertension, Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M.D.
Address Lutindale Date signed 6/13/45

VS 150

G29758

TN. 92606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134B

Registered No. G29758

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-months & 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3719 Chesholm Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George W. Ridgely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18th 1858

8. AGE: Years 87 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Ridgely (D

13. Birthplace Maryland ?

MOTHER

14. Maiden Name Mercier (D

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 6/16/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore Md

18 (a) Funeral director E. L. Gartner

(b) Address Baltimore Md

19 (a) JUN 14 1945 (b) Thurlington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 10.00

20. DATE OF DEATH June 13th 1945 19 , at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1945, to June 13 19 45 and that I last saw him alive on June 13th 19 1945

Immediate cause of death Hemorrhage from W.D. Tract cause unknown Generalized arteriosclerosis

Duration: 2 hrs ? ? ?

Due to Arteriosclerotic Heart disease

Due to

Other Conditions Cystitis due to bladder Calculi

(Include pregnancy within 3 months of death)

Date of operation 5-7-45

Major findings of operation: Bladder Calculus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E J Perry M.D.

M. D.

Address Baltimore City Hospitals Date signed 6/14/45

VS 150

G29759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town [redacted] Hooperville
(If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Travers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18-05

8. AGE: Years	Months	Days	If less than one day
39	9	26	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Waterman

11. Industry or business

FATHER
12. Name Henry Travers
13. Birthplace Md

MOTHER
14. Maiden Name Nora Tyler
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL 6/16/45

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or ~~crematory~~ Dorchester Mem. Cemetery
Location Cambridge, Md.

18 (a) Funeral director Edward Mitchell & Sons
(b) Address 1900 Eutaw Place Huntington Williams, Mgr.

JUN 14 1945
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 10 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 13 1945 and that I last saw him alive on June 13 1945.

Immediate cause of death	Duration
Hypertension & Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/11/45

Major findings of operation Hypertension & Hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] Date signed 6/15/45
Address [redacted] Md.

G29760

HEALTH DEPARTMENT—CITY OF BALTIMORE

G29760

CERTIFICATE OF DEATH

1600 C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Collington Ave. St., 5 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Girl Runge

If U. S. Veteran specify WAR

(a) Residence: No. 414 S. Collington Ave. Street Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) June 10-45

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 10 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Jos Runge

14. BIRTHPLACE (city or town) (State or country) Jolivue City Va

MOTHER

15. MAIDEN NAME Va. Breitling

16. BIRTHPLACE (city or town) (State or country) Agnesdale Va

17. INFORMANT Mother
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place UNIVERSITY MEDICAL SCHOOL JUN 13 1945 19

19. UNDERTAKER Commissioner of Health
(Address)

20. JUN 14 1945 H. Stanley Williams M.D.
(Signature of Registrar)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 10, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 10, 1945 to June 10, 1945

I last saw h... alive on ..., 19... Death is said to have occurred on the date stated above, at 4:30 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Asphyxia (Breech delivery spontaneous with head caught in vagina)	6-10-45

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) A. Sulland M. D.

(Address) 707 E. Hamilton Ave.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V8 8

62

X

29761

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 131a

Reg. Dist. No.

G29761

1. PLACE OF DEATH:
County 22 [illegible] Hospital Ave
City or town Baltimore md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 2231 Madison Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2231 Madisen ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ella C. Baskerville

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Henry H. Baskerville
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 28 - 1878

8. AGE: Years	Months	Days	If less than one day
67		15	hrs. min.

9. Birthplace: Accomac Co, Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Pitts
13. Birthplace: Accomac Co, Va

MOTHER
14. Maiden name: Charlotte ?
15. Birthplace: ?

16. Informant: Mrs Lottie Washington
Address: 2231 Madison Ave

17. (Burial, cremation, or removal. Which?) Date thereof 6 - 14 - 45 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co
18. Funeral director: J. L. Preston Funeral
Address: 579 Mosher St

19. JUN 14 1945 (Date rec'd by registrar)
20. Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 10 - 1945, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1944 to 6 - 10 1945
and that I last saw him alive on 6 - 9 - 45

Immediate cause of death	DURATION
Cardio Vascular Renal Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. B. Baker M.D.
M. D. or other
Address 2033 Druid Hill Ave Date signed 6/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G29762

Registered No. 14628

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos da

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 32 N. Potomac Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Rossiter, John Joseph

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: [illegible]

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1878

8. AGE: Years: 67 | Months: 3 | Days: — | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Fire Department

11. Industry or business

FATHER

12. Name: John J. Rossiter

13. Birthplace: Ireland

MOTHER

14. Maiden Name: Margaret ?

15. Birthplace: Ireland

16 (a) Informant: Family

(b) Address: 32 N. Potomac St.

17 (a) D. (Burial, cremation, or removal) (b) Date thereof 6-15-45 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park.

Location: Frederick Ave.

18 (a) Funeral director: J. H. Cully

(b) Address: 130 E. Fort Ave.

19 (a) [illegible] (b) Registrar: Huntington Williams M.D.

JUN 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 7:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1945 to June 12 1945, and that I last saw him alive on June 12 1945.

Immediate cause of death: Embolism, pulmonary, following operation. Pancreatitis with obstruction of common bile duct. — Duration

Due to: Calculus of the common bile duct. —

Due to: —

over

Other Conditions: Arteriosclerosis with cardiac failure (Include pregnancy within 3 months of death)

Date of operation: May 7, 1945

Major findings of operation: Exploration of common duct

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Benjamin F. Jones M. D.

Address: U.S. Marine Hospital Date signed 6/14/45

VS 150

Baltimore, Maryland.

G29763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a Registered No. G29763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 N. Smallwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 42yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 N. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (~~Yes~~ No)
If yes, name country —

3 (a) FULL NAME Pearl Litvinsky

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Louis Litvinsky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
71	—	—	hr. — min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation at home
11. Industry or business —

FATHER
12. Name Wolfe
13. Birthplace Russia

MOTHER
14. Maiden Name Emma
15. Birthplace Russia

16 (a) Informant Mrs Pearl Litvinsky
(b) Address 2409 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto. St

19 (a) JUN 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1945 to June 13 1945, and that I last saw ~~him~~ her alive on June 13 1945

Immediate cause of death	Duration
Arterio-sclerosis	
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. Kadrow M. D.
Address 2306 Eutaw Pl Date signed 6-13-45

X

G29764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G29764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Gibbons Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 3607 Gibbons Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Herbig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Michael Herbig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1879

8. AGE: Years 65 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name John Lang
13. Birthplace Balto

MOTHER
14. Maiden Name Susan Snyder
15. Birthplace Balto

16 (a) Informant Mrs Geo R. Otten.
(b) Address 3604 Gibbons Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) JUN 14 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945; at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to June 12 1945. and that I last saw her alive on June 12 1945.

Immediate cause of death Diabetic Coma + Convulsions — Duration 2 hrs

Due to Diabetes Mellitus — Duration several years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. O. Keown

Address 1938 Linden Ave Date signed 6/12/45

approved - Herman B. Madden M.D. - X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29765 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Barclay St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Mooney

3 (b) If veteran, name war	3 (c) Social Security Account No.
0	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Mooney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1875

8. AGE: Years	Months	Days	If less than one day
69 70	6	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Bernard Mooney
13. Birthplace Maryland

MOTHER
14. Maiden Name Molly Hannon
15. Birthplace Maryland

16 (a) Informant John Mooney
(b) Address 2306 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location

18 (a) Funeral director Mary M. Steinhoff
(b) Address 1 E. 22nd St.

19 (a) JUN 14 1945 Registered by Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 6 02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1945 to 6-13 1945, and that I last saw him alive on 6-13 1945.

Immediate cause of death	Duration
CORONARY OCCLUSION	
Due to ARTERIOSCLEROTIC HEART DISEASE.	
Due to GENERALIZED ARTERIO SCLEROSIS DUE TO SENILITY.	
Other Conditions A-S. GANGRENE OF RT. FOOT AMPUTATION (MIDTHIGH) LT LEG MIDDLE THIRD	

(Include pregnancy within 3 months of death)
Date of operation 6-12-45
Major findings of operation: GENERALIZED ARTERIOSCLEROSIS & GANGRENE.
of autopsy: PERMISSION NOT OBTAINED.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Lockard
Address Church Home & Hosp. Date signed 6-13-45 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1825

Registered No. G29766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. 2 m.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1939

8. AGE: Years 6 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jas. R. Conner.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Alberta Halliard
15. Birthplace Col.

16 (a) Informant Mr. Jas. Conner.
(b) Address 2406 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location

18 (a) Funeral director Wilson Woodfield
(b) Address 501 E. 22nd St.

19 (a) JUN 11 (Date rec'd by registrar) (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945 at 3:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation due to caved.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 8, 1945 at 3:30 P.M.
(b) Where did injury occur? Yard - 2525 Brook Road Md American Sewing & Contracting Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? No.
(d) Means of injury Cave-in of sand pile.

23. Signature Howard A. Mahaffie M.D. Medical Examiner.
Date signed June 13, 1945.

VS 151

G29767 G29767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 E. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town Rural — Star Route
(If outside city or town limits, write RURAL and give town)
(d) Street No. Star Route
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Emma Jane Archer

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Allen Archer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 30 1857

8. AGE: Years 88 | Months — | Days 15 14 | If less than one day hr. min.

9. Birthplace Essex County, Va.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Benjamin Purdue
13. Birthplace Essex County, Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. I. M. Simms

(b) Address 222 E. Lafayette Ave.

17 (a) Burial (b) Date thereof 6-15-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bedford Cem.

Location Petersburg Va.

18 (a) Funeral director Geo. M. Thompson

(b) Address 501 E. Lafayette St.

19 (a) [illegible] (b) [illegible]
(Place of disposition) (Signature of local registrar)

JUN 16 1945 Huntington, W. Va.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 6 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to June 13 1945 and that I last saw her alive on June 12 1945

Immediate cause of death	Duration
Arteriosclerosis	20 yrs.
Chr. myocarditis	3 mos.
Due to Auricular flutter	3 wks.
Due to Heart Block	9 days
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Schlegel M. D.
Address 1600 Liberty St. Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G29768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 W. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Helmick

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Belle

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 9, 1898

8. AGE: Years	Months	Days	If less than one day
47	3	3	hr. min.

9. Birthplace Elkins, W. Va. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Columbus Helmick
13. Birthplace W. Va.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Belle Helmick
(b) Address 403 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/45 (month) (day) (year)
(c) Cemetery or crematory Leedan Hill
Location Annapolis Blvd

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St.

19 JUN 14 1945 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12- 1945, at 1 22 P.M.

21. I certify that I took charge of the remains described above, held an inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above; and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio - vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weidner M.D. Medical Examiner.
Date signed 6-13-45

VS 151

G29769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29769 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret E. Mercer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Enos
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) Feb 15, 1870
8. AGE: Years 75 | Months 3 | Days 28 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Geo. Berget
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Md.

16 (a) Informant Miss Mary Herget
(b) Address 1304 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3800 Frederick Ave

18 (a) Funeral director John F. Kenney Inc
(b) Address 715 Light St Washington Pl

19 JUN 14 1945 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945, to 6/12/ 1945, and that I last saw h-er alive on 6/12/ 1945.

Immediate cause of death: Asphyxia — Duration
Due to: cerebral hemorrhage
Due to: arteriosclerosis of the brain extensive
Other Conditions
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Weinberger M. D.
Address 102 E. Fort Ave Date signed 6/13/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1212 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Williams Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	9	hr. min.

9. Birthplace Sussex Co. Va.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Epps
15. Birthplace Va

16 (a) Informant Mary Williams
(b) Address 1212 E. Preston St

17 (a) Removal (b) Date thereof 6/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Little Mt. Cem.
Location Sussex Co., Va.

18 (a) Funeral director Joseph S. Lochte
(b) Address 1504 N. Central Ave

19. (a) (Signature of city registrar) (b) Huntington Williams, Registrar

JUN 14 1945

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 6/13 1945, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 1945, to 19, and that I last saw h~~im~~ alive on 6-13 1945.

Immediate cause of death Uremia

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days
3

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Williams M. D.

Address 1222 N. Carolina Ave. signed 6-14-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G29771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marvin M. Todd

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2. 1944

8. AGE: Years	Months	Days	If less than one day
1	2	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Arlie Mc. Kinley Todd
13. Birthplace Augusta Co. Va.

MOTHER
14. Maiden Name Ethel D. Robertson
15. Birthplace Rockbridge Co. Va

16 (a) Informant Arlie Todd
(b) Address 11 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 1045 W. Fayette St

19 (a) JUN 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 to June 13 1945, and that I last saw him alive on Jun 15 1945.

Immediate cause of death Respiratory failure — Duration

Due to Pneumonia

Due to

Other Conditions Mongolism Idiocy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Abrahams MD
Address 601 N. Market St Date signed 6/15/45

VS 150

G29772 42 BALTIMORE CITY HEALTH DEPARTMENT 159 G29772

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-45

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bernard Matson
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Johnson
15. Birthplace Md

16 (a) Informant Dorothy Johnson
(b) Address 428 N. Carey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Sam'l W. Chase Sons
(b) Address 638 N. Eutaw St

19 (a) (b) Huntington Mills, Md
(Date rec'd by registrar) (District)

JUN 14 1945

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945 at 10:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 11 1945. and that I last saw h IM alive on June 11 1945.

Immediate cause of death Premature

Due to Died See Stillbirth

Due to Cert. # 33275

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Petrine Dodd, M.D.

Address University Hosp. Date signed 6/13/45

See Stillbirth Certificate # 33275

G29773 Dr Isaac Dickson 3055 W. North Ave La 0494 G29773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3104 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C. Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Emma C. Wade

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1859

8. AGE: Years 85 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business Building

FATHER
12. Name Uakuoon Wade
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Lawrence Stenger
(b) Address 4712 Dartford Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St.

19 (a) 6 14 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945 to June 11-1945 and that I last saw him alive on June 11-1946

Immediate cause of death: Chronic Myocarditis
Due to: Diabetes Mellitus

Duration
9 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac L. Dickson M. D.
Address 3055 W. North ave Date signed 6/15/45

VS 150

X

G29774

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

JL - 82464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G29774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 11 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(or) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George A. (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Old Aged Pension
11. Industry or business

FATHER
12. Name Albert James Massey
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Catherine Holland
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

JUN 14 1945 (Huntington Williams Md.)
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 45 to June 12 45, and that I last saw her alive on June 12 1945.

	Duration
Immediate cause of death: Lobar pneumonia	4 days
Due to: Cachexia	2 yrs.
Due to: Carcinoma of rectum with metastasis	3 yrs.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation 2-11-42
Major findings of operation: Carcinoma of rectum
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hauck E. Ballou M. D.
Address Balt. City Hosp. Date signed 6/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29775 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 - St Johns Rd
(c) Hospital or institution: Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Mt. Royal Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Whitehoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1857

8. AGE: Years 87 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Whitehoff
13. Birthplace Germany

MOTHER
14. Maiden Name Ellen Gatch
15. Birthplace Md

16 (a) Informant Mrs Antonio Del Grosso
(b) Address 2316 Sulgrave Ave

17 (a) Burial (b) Date thereof June 14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W Jenkins Son Co
(b) Address McCulloh & Orchard

19 (a) Huntington Williams, M.D.
(Date received by Registrar)

VS JUN 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 11 46 AM

21. I certify that death occurred on the date above-stated; that I attended deceased from Feb 1944, to June 13 1945, and that I last saw h[illegible] alive on June 12 1945.

Immediate cause of death Myocarditis
Arteriosclerosis

Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Moody
Address 1403 Parkside Date signed 6/15/45

G29776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

Registered No. G29776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Arlington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles M. Thompkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-21

8. AGE: Years 24 Months 2 Days 5 If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Thompkins
13. Birthplace S.C.

MOTHER
14. Maiden Name Katie Ferguson
15. Birthplace S.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (month) 17 (day) 45 (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. H. Keelan
(b) Address 1303 Pressman St

19 (a) (Date received by registrar) JUN 14 1945 (b) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1945 to June 13 1945, and that I last saw h[illegible] alive on June 13 1945.

	Duration
Immediate cause of death: Malnutrition	days
Due to: Pulmonary tuberculosis	12 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature John R. Heymaker M.D.
Address Johns Hopkins Hosp Date signed 6/14/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G29727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2434 Etting St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2434 Etting St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pricilla Harvey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fem | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James Harvey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22 1857

8. AGE: Years 87 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Sarah Ware
(b) Address 2434 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Md
Location
18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pleasant
19 (a) (Date rec'd by registrar) JUN 14 1945 (b) Huntington Wolfe Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2, 1945 to June 12, 1945 and that I last saw h alive on June 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 WK.
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Geo. H. Nelson M.D.
Address 1516 N. Monroe (17) Date signed 6-14-45

X

G29778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G29778 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 School Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Foster

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/1916

8. AGE: Years	Months	Days	If less than one day
29		14	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Oliver Foster
13. Birthplace Md.

MOTHER
14. Maiden Name Deanna Ennals
15. Birthplace Md.

16 (a) Informant Andrew Foster
(b) Address 1815 Pressman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/45 (mo.) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelso
(b) Address 1303 Pressman St.

19 (a) (Date rec'd by registrar) JUN 14 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1945, at 2 M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Chronic Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert L. Graham M.D.
Medical Examiner.
Date signed June 13 1945

G29779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G29779

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5315 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina E. Treulieb

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Treulieb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1865

8. AGE: Years: 80 | Months: 5 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Home Duties

11. Industry or business

FATHER
12. Name: Henry Rumohr
13. Birthplace: Germany

MOTHER
14. Maiden Name: Magdalena Anacker
15. Birthplace: Germany

16 (a) Informant: Mr. John Treulieb
(b) Address: 2146 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-45 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location:

18 (a) Funeral director: Frederick A. Cole
(b) Address: 3911 Edmondson ave

19 JUN 14 1945 (Date rec'd by registrar) Huntington Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to June 12 1945, and that I last saw h[illegible] alive on June 12 1945.

Immediate cause of death: Chr. Thyroiditis

Duration: 1 yr

Due to: Generalized Arteriosclerosis

Due to: Salivoma

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Anne Intowell

Address: 515 Frederick Rd. Date signed 6/15 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29780

473986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G29780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Melrose Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lolarance Singleton Hall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 3-5-96

8. AGE: Years 49. Months 3 Days 7 If less than one day .....hr. .....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Julius Hall
13. Birthplace Md

MOTHER
14. Maiden Name Susan Nudent.
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSP.

17 (a) Burial (b) Date thereof 6-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Balto Co. Md.

18 (a) Funeral director Mrs. Frances A. Abernethy
(b) Address 578 W. Biddle St.

19 (a) JUN 14 1945 (b) Registrar's signature Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 12 1945 at 8. P M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 16 1945 to June - 12 1945 and that I last saw him alive on June - 12 1945

Immediate cause of death Uremia
and anuria

Duration 12d.

Due to Bilateral ureteral obstruction

Due to Extension of Ca of rectum

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation: Ca of rectum

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature E. Lyle Wilson X WILSON
Address Johns Hopkins Hosp. Date signed 6-15-45 M.D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3328 Gwynns Falls Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 Gwynns Falls Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachael Leah Borenstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aaron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Elizer Cooper
13. Birthplace Russia

MOTHER
14. Maiden Name Zelda ?
15. Birthplace Russia

16 (a) Informant Harry Borenstein
(b) Address 3328 GwynnsFalls Parkway

17 (a) Burial (b) Date thereof June 15, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

JUN 14 1945 (Mortician for Williams) M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1944, to 6/10 1945
and that I last saw h[illegible] alive on 6/10 1945.

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature 733 Augusta St M. D.
Address 6/14/45 Date signed

VS 150

X

G29782 G29782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address --
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William D. O'Brien

3 (b) If veteran, name war --

3 (c) Social Security Account No. 214-03-5918

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia A. O'Brien
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1906

8. AGE: Years	Months	Days	If less than one day
38	9	7	hr. min.

9. Birthplace Atlanta, Ga.
(Town, county, and state)

10. Usual Occupation Agent

11. Industry or business Metropolitan Life Ins. Co.

FATHER
12. Name William J. O'Brien
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mazee L. Danforth
15. Birthplace Atlanta, Ga.

16 (a) Informant Mr. Thomas R. O'Brien, brother
(b) Address 3227 Lyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) JUN 14 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 6 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to June 13 1945 and that I last saw H.[illegible] alive on June 13 1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Myocardial failure	
Due to Pneumonia, lobar	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Fisher M.D.
Address Sinai Hosp. Date signed 6/13

L. Tucker, M.D.

G29783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29783 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Chesholm Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Chesholm Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES R. EMICH

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Henrietta S. Emich
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 28, 1866
8. AGE: Years 78 | Months 11 | Days 15 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Charles Lander
13. Birthplace: Pa.

MOTHER
14. Maiden Name: -- Foreman
15. Birthplace: Pa.

16 (a) Informant: Mrs. Frederick Kipp
(b) Address: 3705 Chesholm Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) (b) JUN 14 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1945 at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11, 1945 to June 13, 1945 and that I last saw him alive on June 11, 1945.

Immediate cause of death	Duration
Coronary thrombosis	3 days
Due to	
Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Stubblett M.D.
Address 2220 Garrison Blvd. Date signed 6/14/4

Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135a

G29784 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Ridgely St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1014 Ridgely St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET S. ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1861

8. AGE: Years	Months	Days	If less than one day
83	6	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John G. Robinson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mina E. Tucker
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mina Schofield
(b) Address 1014 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 1 (Date received by registrar) (b) 1945 Huntington Willis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1945, at 9:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945 to June 12 1945 and that I last saw her alive on June 12 1945.

	Duration
Immediate cause of death Respiratory failure	12 hrs.
Due to Pulmonary edema	36 hrs.
Due to Hypostatic pneumonia	9 days
Other Conditions Senility; cystitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address 212 Kolb Ave. Date signed 6/14/45

VS 150

G29785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29785 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Dukeland St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Dukeland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter J. Darby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary B. Callahan 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1889

8. AGE: Years	Months	Days	If less than one day
56	4	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business White Iron & Metal Co.

FATHER
12. Name Peter Darby
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann O'Shaneesey
15. Birthplace Ireland

16 (a) Informant Mrs Mary B. Darby
(b) Address 910 Dukeland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3700 old Frederick Rd.

18 (a) Funeral director Harry A. Wilkie
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945, to June 13 1945, and that I last saw him alive on June 6 1945.

Immediate cause of death	Duration
Coronary Thrombosis	8 hrs
Due to Hypertension C.V.D.	
Arteriosclerosis.	7 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Ashman M. D.
Address 1201 Poplar Grove St Date signed 6-13-45

X

G29786

G29786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1243

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave.
(c) Hospital or institution: Saint Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Hollins St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph A Martin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Nellie P
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) July 29 1901 ~~43 years~~
8. AGE: Years 43 | Months 10 | Days 16 | If less than one day ..... hr. ..... min.
9. Birthplace Philadelphia (Town, county and state)
10. Usual Occupation Steam fitter
11. Industry or business

FATHER
12. Name Joseph A. Martin
13. Birthplace Phila Pa

MOTHER
14. Maiden Name Saulyny
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. Nellie P. Martin
(b) Address 1304 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 JUN 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1945 to 6/13 1945, and that I last saw h[illegible] alive on 6/13 1945

Immediate cause of death Cardiac Failure — Duration

Due to Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Cirrhosis of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Bryson
Address St. Agnes Hospital Date signed 6/13/45 M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29787

DeHaven

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G29787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Lakeside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. DeHaven

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-70

8. AGE: Years 74 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John T. Dinningan
13. Birthplace Ireland

MOTHER 14. Maiden Name Kathryn Moffett
15. Birthplace Ireland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-45 (month) (day) (year)
(c) Cemetery or crematory Abr. Bath
Location Old Frederick Rd.

18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 12 1945 and that I last saw her alive on June 12 1945

Immediate cause of death: Carcinoma of Rectum — Duration

metastatic to liver & mesentery — 18 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Richter M.D.
Address Johns Hopkins Hospital Date signed 6/12/45

VS 150

G29788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29788 Registered No. 469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W. Va. (b) County

(c) City or town Portsmouth (If outside city or town limits, write RURAL and give town)

(d) Street No. 533 Harrison St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Clara B Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John W. Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	11	hr. min.

9. Birthplace Irondale, Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Charles McCarel

13. Birthplace Ohio

MOTHER

14. Maiden Name Viola Hichman

15. Birthplace W. Va.

16 (a) Informant Mr. John W. Roberts

(b) Address 533 Harrison St., Portsmouth, Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)

(c) Cemetery or crematory Elwood Cem.

Location Elwood, Ind.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUN 14 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13 1945, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 6/13 1945.

and that I last saw h. alive on 6/13 1945.

Immediate cause of death	Duration
(a) Head Injury	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Rubye D. Lerman

Address Lerman Hospital Date signed 6/14

VS 180

G29789 — BALTIMORE CITY HEALTH DEPARTMENT — G29789

CERTIFICATE OF DEATH

Registered No. 832a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 N Charles St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 N Charles St (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Catherine Garvey

3 (b) If veteran, name war — no —
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Maurice J. Garvey
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 28 1863

8. AGE: Years 81 | Months 7 | Days 17 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name John A. Irvin
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Claudia
15. Birthplace Baltimore

16 (a) Informant Mrs. C. H. Keller (daughter)
(b) Address 1128 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Steuart Money Co.
(b) Address 1518 N Charles

19 (a) JUN 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1945, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1945, to June 12th 1945, and that I last saw h.e. alive on Jan 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days

Due to: Arteriosclerosis — Duration: 5 years

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ___ at ___ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. Collins M. D.
Address 206 N Calvert St Date signed June 14 1945

X

G29790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29790 Registered No. 944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7122 HARFORD RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7122 HARFORD RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. LOUIS SEIDMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CELIA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name SOLOMON

13. Birthplace RUSSIA

MOTHER 14. Maiden Name FRUMA

15. Birthplace RUSSIA

16 (a) Informant HOWARD B. SEIDMAN

(b) Address 7122 HARFORD RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-15-45 (month) (day) (year)

(c) Cemetery or crematory Mount Hebrew

Location

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO. ST

19 (a) JUN 14 1945 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14-45 19 , at 6 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12-1945 to 6-14 1945, and that I last saw him alive on 6-12-1945

Immediate cause of death Coronary Thrombosis — Duration 1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davidson M. D.

Address 3218 Edstern ave Date signed 6-14-45

JUN 14 1945

X

G29791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170c

G29791 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside town, write RURAL and give town)
(d) Street No. 1311 River Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER E. ~~HANSFORD~~ Hansford

3 (b) If veteran, name war

3 (c) Social Security Account No. 233-24-8009

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29th 1884

8. AGE: Years ~~60~~ 61 | Months 2 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Elkins W. Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lehap D. Hansford
13. Birthplace Elkins W. Va

MOTHER
14. Maiden Name Emmica Curtis
15. Birthplace Elkins W. Va.

16 (a) Informant Mr R. L. Hansford
(b) Address 340 S. Broadst Woodberry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-45 N.D. (month) (day) (year)

(c) Cemetery or crematory
Location Elkins W. Va

18 (a) Funeral director Lee G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) [illegible] 1945 (b) by registrar Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1945, at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull; Crushed chest; Fracture of back

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-13-45 at 2:00 A. M. 25/5
(b) Where did injury occur? 4500 bk. Pennington Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Grattan M.D. Medical Examiner.
Date signed June 13 1945

G29792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29792 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 N. Robinson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Robinson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Downs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Lillian M. Downs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/18[illegible]6

8. AGE: Years	Months	Days	If less than one day
78	8	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Harry C. Downs
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Herbert Downs
(b) Address 721 N. Robinson

17 (a) burial (b) Date thereof 6-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location O'Donnell Street

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 3019 E. Monument Street

JUN 13 1945 (b) Registrar Huntington Williams, M.D. Registrar

JUN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1945, at 12.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2nd 1940 to June 12th 1945 and that I last saw h[illegible] alive on June 12th 1945

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to Cardio-vascular disease	5 yrs
Due to {Myocardial degenerat Arteriosclerosis}	
Other Conditions Secondary anemia	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature A. T. Ris M. D.
Address 24 S. Broadway Date signed June 14 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G29793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3923 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boyd L Fite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence M Fite

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1907

8. AGE: Years 38 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Stanley, Hardy Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Fite
13. Birthplace Va.

MOTHER
14. Maiden Name Estelle Mitchell
15. Birthplace Va

16 (a) Informant Records St. Agnes Hospital
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 E Fayette St

19 JUN 15 1945 (b) Huntington West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1945 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1945 to 6/14 1945 and that I last saw him alive on 6/14 1945

Immediate cause of death: Ruptured Appendix Peritonitis

Due to

Due to

Other Conditions: none known (Include pregnancy within 3 months of death)

Date of operation 6/8/45

Major findings of operation: Ruptured appx

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard W Stier
Address St Agnes Hospital Date signed 6/14/45 M.D.

X STIER

VS 150

G29794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G29794 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4605-York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4605-York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Bowman Robbinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: John Robbinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20-1914

8. AGE: Years 31 Months 0 Days 24 If less than one day hr. min.

9. Birthplace Greensboro NC.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sophus J.C. Bowman
13. Birthplace NC

MOTHER
14. Maiden Name Sophy Bowman
15. Birthplace NC

16 (a) Informant John Robbinson
(b) Address 4605-York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-45 (month) (day) (year)

(c) Cemetery or crematory
Location Greensboro NC

18 (a) Funeral director LeRoy Hedges.
(b) Address 4644 York Rd.

19 (a) JUN 15 1945 (Date rec'd by registrar) Huntington Williams, M.D.

V8 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 6.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1945, to June 13 1945, and that I last saw h[illegible] alive on June 4 1945.

Immediate cause of death: Carcinoma of Uterus — Duration: 6 mo.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A.S. Chalfant M. D.

Address 6710 York Rd Date signed June 14 1945

G29795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

✓ G29795 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 St. Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Garvin-Erdman

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-10-6463

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Wilbur W. Erdman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1874

8. AGE: Years	Months	Days	If less than one day
71	1	4	hr. min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Dress Linen Room Clerk

11. Industry or business Balto. Steam Packet S.S. Co

FATHER
12. Name Tough Gallagher
13. Birthplace N. Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Albert A. Sauer
(b) Address Box 398 A Route 3 Essex 21

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St

19 (a) JUN 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1945, at 10 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945 to June 14 1945 and that I last saw h alive on June 14 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hrs
Due to Arterio-sclerosis Hypertension	15 yrs
Due to Chronic Myocarditis with Decompensation	10 yrs
Other Conditions Chronic Bronchitis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Zierler M. D.
Address 2318 Eutaw Place Date signed 6/14/45

G29795

FL - 93905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G29796

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 1257

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2613 Hampden Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Micheal Walz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Blandina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	1	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Walz

13. Birthplace Germany

MOTHER

14. Maiden Name Marguerite

15. Birthplace Germany

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 (a) JUN 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945, to June 14 1945, and that I last saw him alive on June 14 1945.

Immediate cause of death	Duration
Hypostatic pneumonia	24 hrs
Due to Hemiplegia Rt. & Cerebral accident	1 wk
Due to	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-6-45

Major findings of operation: Markedly enlarged prostate

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E J Berry M.D. M. D.

Address Baltimore City Hosp. Date signed 6/17/45

G29797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G29797

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto.
(b) Street address 1517 Laurens St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Henry Leggens
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Corena Leggens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Spartanburg S. C. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER 12. Name John Leggens
13. Birthplace S. C.

MOTHER 14. Maiden Name Amanda Hardy
15. Birthplace S. C.

16 (a) Informant Corena Leggens
(b) Address 1517 Lauderdale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/45 (month) (day) (year)
(c) Cemetery or crematory
Location Spartanburg S. C.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 W. Mount St

JUN 15 1945 Huntington Williams (Date filed) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13 1945, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1945, to 6/13 1945, and that I last saw h[illegible] alive on 6/13 1945.

Immediate cause of death Hypertension Type Heart Disease — Duration
Due to Hypertension
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan X Bilkes, M.D.
Address 609 N. Calhoun St. Date signed 6/14/45

Evan X Bilkes

G29798
CWK-30478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93C

G29798
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 4- 12
(e) Length of stay in Baltimore (yrs., mos., or days) 35- 4- 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1249 James Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Letkauskey (LETKOWSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7-1910

8. AGE: Years	Months	Days	If less than one day
35	4	6	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Letkauskey
13. Birthplace Lithuania

MOTHER
14. Maiden Name Frances Scripkunis
15. Birthplace Lithuania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof June 16-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Blair Rd

18 (a) Funeral director Joseph Kaminskas
(b) Address 606 E Washington Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

VS Form JUN 15 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1938, to June 13 1945, and that I last saw h im alive on June 13 1945.

Immediate cause of death Congestive heart failure — Duration 2 mo

Due to arteriosclerotic heart disease — Duration 7

Due to — Duration

Other Conditions Rheumatoid arthritis — Duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Gilliss
Address Balt City Hosp Date signed 6-13-45 M. D.

G29799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G29799 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 N Milton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida A. Cornelius

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James A. Cornelius
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1864

8. AGE: Years 80 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Wm. Ashberry
13. Birthplace Va.

MOTHER 14. Maiden Name Nancy Hunter
15. Birthplace Va.

16 (a) Informant Lois Ross
(b) Address 626 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16-45 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location Mathews Co. Va.

18 (a) Funeral director John L. Miller
(b) Address 2034 Jefferson St.

19 (a) JUN 15 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to June 15 1945 and that I last saw h alive on June 12 1945

Immediate cause of death Acute Cardiac Failure — Duration 12 hours

Due to Cancer of Cervix — Duration 1/2 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E Monument St signed

Huntington Williams, M.D.

X 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29800 ✓ G29800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymond
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Henry Graef

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sadie Graef

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1880

8. AGE: Years 64 | Months 8 | Days 12 | If less than one day ....hr. ....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Hotel

FATHER
12. Name Henry B. Graef
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Heinz
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Esther W. Howard
(b) Address Roaches Lane Reisterstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) Filed JUN 15 1945 Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to June 12 1945, and that I last saw h(im) alive on June 12 1945.

Immediate cause of death Pulmonary Tuberculosis

Due to Tuberculosis of Left Leg

Due to Gangrene of Left Foot

Due to Arteriosclerosis cardiovascular disease

Other Conditions Chronic Glomerular nephritis — Pulmonary edema

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abel L. Baldwin M.D.

Address West Baltimore General Hospital Dated 6/12/45

X

G29801

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 93 C

CERTIFICATE OF DEATH

Registered No. G29801

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Parkland & Raynor Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto County
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Maryland Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Koermer Frank J. Koermer

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-4590

4. Sex: M. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna T. Smith

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 3, 1894

8. AGE: Years 50 | Months 11 | Days 10 | If less than one day X hr. X min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Bricklayer helper

11. Industry or business Standard Oil

FATHER
12. Name Peter Paul Koermer
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Eva Weber
15. Birthplace Baltimore Md

16 (a) Informant Mrs Anna T. Koermer
(b) Address 415 Maryland Ave. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Balto

18 (a) Funeral director George J. Ruth Inc
(b) Address 1735 Bluford Ave

19 JUN 15 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 10 ~~P~~ A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to June 13 1945, and that I last saw him alive on June 13 1945.

Immediate cause of death (a) Coronary thrombosis
Coronary failure
Pulmonary infarction
Due to (b) Rheumatic cardiac valvular disease
Due to (c) Coronary artery disease
Other Conditions Thrombo phlebitis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard Lee Baldwin M. D.
Address West Baltimore General Hospital Signed 6/13/45

VS 150

G29802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G29802
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Hudson street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Fountain Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Szamborski Szamborski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1886

8. AGE: Years 59 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Adam Szmurch

(b) Address 2624 Hudson street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 16 45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

16 (a) Funeral director John M. Weber

(b) Address 401 S. Chester street

19 (a) JUN 15 1945 (Date received by registrar) (b) Huntingtown Williamsburg, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 2:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 13 1945, and that I last saw him alive on June 12 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	36 hrs.
Cachexia. Edema	"
Due to Lobar Pneumonia	2 wks
Other. tbc?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rose D'Lyzio M. D.
Address Date signed 6/14/45

VS 150

G29803 475076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 157E

Registered No. G29803

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7423 Brentwood Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. Denver, III

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 9-10-43

8. AGE: Years 1 | Months 9 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William Denver

13. Birthplace Md.

MOTHER — 14. Maiden Name Margaret Eckart

15. Birthplace Md.

16 (a) Informant Parents.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45. (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem. Location Eastern Ave. Rd.

18 (a) Funeral director Charles S. Zeiler

(b) Address 3695 Fait Ave. Huntington-Williams, M.E.

19 (a) JUN 15 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1945 to June 13 1945 and that I last saw him alive on June 13 1945

Immediate cause of death	Duration
Thrombosis pulmonary artery	1 day.
Due to Post-operative -	
Due to	
Other Conditions Congenital heart disease (Indicate primary cause by underscoring)	

Date of operation 6/12/45

Major findings of operation: Congenital Heart disease

of autopsy: Thrombosis pulmonary artery

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. M. Tevens M. D.

Address J. H. H. Date signed 6/13/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE B. TODD

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Martin L. Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1874

8. AGE: Years	Months	Days	If less than one day
71	5	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Josiah Gardner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Riali
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Thelma B. Shropshire
(b) Address 807 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 15 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1945 to 6/14 1945 and that I last saw h[illegible] alive on June 13 1945

Immediate cause of death Coronary thrombosis — Duration 2 hours

Due to General sclerosis — 4 years

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M. D.
Address 811 Preston St Date signed 6/16/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29805 G29805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 Tamworth Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Tamworth Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICKA A. LLOYD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank L. Lloyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	14	hr. min.

9. Birthplace Buffalo, N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Brueck
13. Birthplace -

MOTHER
14. Maiden Name Fredricka Krueger
15. Birthplace O--

16 (a) Informant Mrs. Ricka L. Fisher
(b) Address 81[illegible] Hatherleigh Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) JUN 15 1945 (b) Registrar Hunting for Wm

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to June 14 1945, and that I last saw h[illegible] alive on June 13 1945.

Immediate cause of death Cerebral hemorrhage & paralysis — Duration About 8 mo.
Due to Advanced arterio sclerosis — ?
Due to Hypertension — 5 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter L. Burkett M. D.
Address 220 Harrison Blvd - June 15/45 Date signed

G29806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29806 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene sts.
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel J. Blight

3 (b) If veteran, name war: Spanish

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna S. Blight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/29/1868

8. AGE: Years 76 | Months 8 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Chile, South America
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Insurance (retired)

FATHER
12. Name Samuel J. Blight
13. Birthplace England

MOTHER
14. Maiden Name -- Hines
15. Birthplace --

16 (a) Informant Wife (Mrs. Anna S. Blight)
(b) Address 2517 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 15 1945 (Date rec'd by registrar)

(b) Huntington Nitkowski, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 11 39 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1945, to 6-13 1945, and that I last saw him alive on 6-13 1945

Immediate cause of death	Duration
uremia	
hypertensive cardiovascular renal disease	
Due to	
Due to	
Other Conditions old rt. hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Lyon M. D.
Address University Hospital. Date signed 6-18-45

VS 150

X

G29807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2315 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Field Meredith

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry Wilson Meredith

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.): March 5, 1869

8. AGE: Years 75 | Months 3 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: -

11. Industry or business

FATHER
12. Name: John A. Field
13. Birthplace: Providence, R. I.

MOTHER
14. Maiden Name: Catherine Goforth
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Florence F. Ridely
(b) Address: Easton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) JUN 15 1945 (b) Registrar

VS 151

Huntington-Wallingford, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 - 1945 at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio - Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard D. Meredith M.D. Medical Examiner.
Date signed 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G29808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Falls Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 57
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John S. Shay.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Stella M. Shay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1881

8. AGE: Years 63 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Foreman.
11. Industry or business Balto City.

FATHER
12. Name John Shay.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Alice Dennis.
15. Birthplace Maryland.

16 (a) Informant Stella M. Shay.
(b) Address 4007 Falls Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16/45 (month) (day) (year)
(c) Cemetery or crematory Forrestor.
Location Balto Co. Md.

18 (a) Funeral director Thanower & Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) JUN 15 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1945 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1945 to June 13 1945, and that I last saw h[illegible] alive on June 13 19 45

Immediate cause of death	Duration
Cardiac Asthenia	1 da
Due to Sarcoma of Leg.	6 mo
Due to Cancer Lung.	2 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Evans M. D.
Address 1202 S. Ann St. Date signed June 15/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G29809

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2126 Druid Park Drive.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-8

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2126 Druid Park Drive (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Benjamin F. Harris.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-4175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower.

6 (b) Name of husband or wife Flada J. Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) march 24, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	20	hr. min.

9. Birthplace maryland. (Town, county, and state)

10. Usual Occupation Textile Worker.

11. Industry or business Wm. E. Hooper & Sons.

FATHER 12. Name John Harris.

FATHER 13. Birthplace maryland.

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Unknown.

16 (a) Informant Charles H. Harris.

(b) Address 2126 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn.

Location

18 (a) Funeral director Thomas P. Donovan

(b) Address 3615-17 Eastern Ave.

19 (a) (Date received by Registrar) JUN 15 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1945 at 8 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 13 1945, and that I last saw him alive on June 13 1945.

Immediate cause of death: Congestive Heart Failure — Duration 3 days

Due to: Ch. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edw. J. Hassman

Address 4037 Falls Rd. Date signed 6/16/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 Warren Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 22 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Warren Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. 520-36-4100

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr — 1877

8. AGE: Years 68 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Borrell Business

11. Industry or business —

FATHER
12. Name Edward Hughes
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Cora M. Dennis
(b) Address 102 Warren Ave.

17 (a) Burial (b) Date thereof 6/18/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan Co
(b) Address 901-03 Gallows St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 1 JUN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to June 14 1945 and that I last saw alive on June 10 1945

Immediate cause of death Pulmonary Edema

Due to Hypertension Cardio-vascular Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. L. Friedman M.D.

Address 1319 Cathedral St. Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G29811

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 Gold Spring Lane

(c) Hospital or institution Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 913 Hollins St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Otto Waitekeune

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Eva Waitekeune

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1866

8. AGE: Years 78. Months Days If less than one day hr. min.

9. Birthplace Lithuania (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Lithuania

MOTHER 14. Maiden Name Unknown

15. Birthplace Lithuania

16 (a) Informant Mrs. Eva Waitekeune

(b) Address 913 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Govan & Son

(b) Address 901-03 E. Hollins St.

19 (a) (Date rec'd by registrar) (b) Hunting Town, Md.

JUN 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 9:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945, to June 13 1945, and that I last saw h[im] alive on June 12 1945.

Immediate cause of death: valvular heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. N. Patterman M. D.

Address 2024 Reisterstown Rd. Date signed 6/13/45

(over)

G29812

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29812

CERTIFICATE OF DEATH 122a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County.....
(c) City or town Cayce
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Dobie A. Spigner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William L.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-1-03

8. AGE: Years 41 | Months 9 | Days 14 | If less than one day .....hr. .....min.

9. Birthplace D. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name William Reese

13. Birthplace D.C.

MOTHER — 14. Maiden Name Susan Padgett

15. Birthplace D.C.

16 (a) Informant Responsible

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, ~~Cremation, or removal~~) (b) Date thereof 6/15/45 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Shiloh

Location West Columbia S.C.

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1900 Eutaw Place

(c) Filed JUN 15 1945 Date received by Registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 9:13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to June 15 1945 and that I last saw h[illegible] alive on June 5 1945

Immediate cause of death Resp. failure

Due to diaphragmatic hernia

Due to strangulated bowel + colon

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation 6-14-45

Major findings of operation: Correction thru Lft diaphragm strangulated bowel + gangrene

of autopsy: Pleural cavity

Duration
Strangulated for about 10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Alan C. Woods Jr.

Address Johns Hopkins Hospital Date signed 6/15/45

VS 150

G29813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G29813

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert and 33rd. Sts

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Towson (If outside city or town limits, write RURAL and give town)

(d) Street No. 614 Highland Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Benjamin Rush Powell

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. E. R. Powell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-1867

8. AGE: Years	Months	Days	If less than one day
78	9	20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER 12. Name Dr. Benjamin R. Powell

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Annie Howard Hamburg

15. Birthplace Maryland

16 (a) Informant Mrs. Ethel E. Powell

(b) Address 614 Highland Ave, Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill, Location Towson, Md.

18 (a) Funeral director John D. Mitchell Sons Inc

(b) Address 1900 Eutaw Place

19 (a) JUN 15 1945 (Date received by Registrar) (b) Livingston Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14 1945, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-45 1945 to 6-14 1945, and that I last saw him alive on 6-13 1945.

Immediate cause of death Cardio respiratory Failure — Duration

Due to Arteriosclerotic Gangrene

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-19-45

Major findings of operation: Arterio sclerotic gangrene left leg

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Alfred E. Steltenkamp M. D.

Address 206 E. 34th St Date signed 6-14-45

G29814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G29814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: PROVIDENT HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 HR.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 STOCKTON STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES BERNARD DUCHETT

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	Colored	S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/9/1925

8. AGE: Years	Months	Days	If less than one day
20	1	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business —

FATHER
12. Name Jos. Jennings
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret L. Duchett
15. Birthplace Md

16 (a) Informant Margaret Thomas
(b) Address 1319 Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Wm. H. Kelso
(b) Address 1303 Pennsylvania Ave

JUN 15 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/14/45 at 6:15 A.M.
(b) Where did injury occur? 1319 STOCKTON STREET
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury JUMPED FROM WINDOW - SECOND FLOOR FRONT.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 14 1945

G29815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G29815 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Wolhelm st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County 3
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Wolhelm st
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Susie Welsh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles Welsh

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 1867

8. AGE: Years	Months	Days	If less than one day
77 78	7		..... hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business —

FATHER
12. Name James H. Jones
13. Birthplace Laurel Md

MOTHER
14. Maiden Name Sarah Fi Short
15. Birthplace Laurel Md

16 (a) Informant A. H. Jones
(b) Address 111 S Gilmor st

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof June 16 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location R.

18 (a) Funeral director A. H. Jones
(b) Address 111 S Gilmor st

JUN 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 14 1945; and that I last saw h— alive on June 13 1945.

Immediate cause of death	Duration
Carcinoma of Left Breast	
Due to	
Due to	
Other Conditions Chronic myocarditis Old Cerebral Hemorrhage (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Albert Seagrott M. D.
Address 1724 W Lombard St Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G29816

Registered No. 60685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo. 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Rural- Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1st. Ave & Crane Hgwy.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Redford Scott

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Obey C. Scott (husband)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1891

8. AGE: Years	Months	Days	If less than one day
53	10	13	hr. min.

9. Birthplace Suffolk, Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. Redford
13. Birthplace Virginia

MOTHER
14. Maiden Name Ella E. Roberts
15. Birthplace Virginia

16 (a) Informant Mr. Obey C. Scott
(b) Address 1st Ave. & Crane Highway Glen Burnie, Md.

17 (a) Removal (b) Date thereof 6/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory -
Location Norfolk, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 15 1945 (b) Huntington Williams, M.D.
(Filed by registrar)

VS 180

MEDICAL CERTIFICATION P.

20. DATE OF DEATH June 14 1945 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945 to June 14 1945, and that I last saw her alive on June 14 1945.

Immediate cause of death	Duration
Carcinoma of the cervix with multiple metastasis	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
Address U. S. Marine Hospital Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$30

Registered No. G29817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimine
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Mc Culloh St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Helen C. Conyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17. 1892

8. AGE: Years 52 | Months 11 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimne Maryland (Town, county and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Benjman Welch

13. Birthplace Baltimne Maryland

MOTHER 14. Maiden Name Maggie Upsher

15. Birthplace Easley Shne S C

16 (a) Informant Mrs Lucy B. Scott

(b) Address 1006½ N 33 St Richmond 19. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16 1945 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimne City

18 (a) Funeral director Eugene Waters

(b) Address 661 West Baltimore Street, Md.

19 (a) JUN 15 1945 (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 8:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to June 17 1945 and that I last saw [illegible] alive on 6/17/45 1945.

Immediate cause of death: Cerebral hemorrhage — Duration 2 d

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature [illegible] M. D.

Address [illegible] Date signed 6/19/45

Dr Van Schuelly
G29818
(2) Transcripts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G29818

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 Malbon Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Malbon Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** James A Farley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Georgia M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 1899

8. AGE: Years 45 | Months 10 | Days 3 25 | If less than one day hr. min.

9. Birthplace West Virginia (town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Not Available
13. Birthplace "

MOTHER
14. Maiden Name Lillian Kelly
15. Birthplace Penna

16 (a) Informant Mrs Georgia M Farley
(b) Address 118 Malbon Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport W. Va.

JUN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to June 13 1945 and that I last saw h alive on June 13 1945.

Immediate cause of death General Carcinomatosis 6 Mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. P. Van Schuelyer M. D.
Address 4815 Edmondson Date signed 6/14/45

X Am #29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G29819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 E.FAYETTE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 E.FAYETTE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY G.KRUSE

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARIE E.KRUSE

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) NOV.21 1896

8. AGE: Years 48 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace A.A.CO.MARYLAND
(Town, county, and state)

10. Usual Occupation SHIP FITTER

11. Industry or business

FATHER
12. Name HERMAN KRUSE
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY HERMANN
15. Birthplace GERMANY

16 (a) Informant MARIE E.KRUSE (WIFE)
(b) Address 3602 E.FAYETTE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 16/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 503 S.WOLFE ST.

JUN 15 1945

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 12 1945, at 11/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to June 12 1945, and that I last saw him alive on June 11 1945

Immediate cause of death	Duration
Cancer of Stomach & Liver	6 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Apr 1945

Major findings of operation: Cancer of Stomach & Liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.

Address 43-9 Lib[illegible] Pl signed June 13

X

G29820 ✓ G29820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Linden Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1938 - 11 - 25

8. AGE: Years	Months	Days	If less than one day
6	6	19	hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation A Child

11. Industry or business

FATHER
12. Name Henry Williams
13. Birthplace N. J.

MOTHER
14. Maiden Name Mary
15. Birthplace Church Hill, Md

16 (a) Informant Mary Williams.
(b) Address 1015 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-'45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
[redacted] L. 1545 N. Fulton Ave.
Washington Williams Mgr.

19 (a) (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 7 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14 1945, to 6/14 1945, and that I last saw h. alive on 6/14 1945.

Immediate cause of death

Pulmonary Cerebral Tuberculosis

Due to

Due to

Other Conditions

Negative

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. J. Campbell,
Address Provident Hospital Date signed 6/17/45

G29821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G29821

Registered No. M-5993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 W Mulberry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 W Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Ann Lee Joan Ann Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/45

8. AGE: Years	Months	Days	If less than one day
-	-	-	3 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James M. Lee
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Orlene Caswell
15. Birthplace Eastern Shore, Md.

16 (a) Informant James M. Lee.
(b) Address 726 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-'45. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (b)
Filed by registrar Registrar

6 15 1945

Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945 to June 13 1945 and that I last saw him alive on June 13 1945

Immediate cause of death Pulmonary Embolism Duration 3 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Date signed 6/13/45

STRAWDER ✓ G29822

G29844423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 12 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 N. Calhoun (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Strawder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, '91

8. AGE: Years 54 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Geo. Strawder

13. Birthplace Md.

MOTHER 14. Maiden Name Martha Levinia Reeds

15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (month) (day) (year)

(c) Cemetery or crematory Fairview Cem.

Location Frederick, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle Street

19 (a) (b)

Registrar

rec'd JUN 15 1945 rec'd

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1945 to June 14 1945 and that I last saw him alive on June 14 1945

Immediate cause of death: Hepato-renal failure

Due to: Cirrhosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 6-4-45

Major findings of operation: Cirrhosis of Liver

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Fuller Jr. M. D.

Address The Johns Hopkins Hosp. Date signed 6-14-45

X

G29823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G29823

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702. Mosher
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702. Mosher
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius P. Pratt

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-6126

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7th 1891

8. AGE: Years	Months	Days	If less than one day
54	4	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John R. Pratt
13. Birthplace Md

MOTHER
14. Maiden Name Ella Jones
15. Birthplace Md

16 (a) Informant Ada M. Jones
(b) Address 702. Mosher

17 (a) Burial (b) Date thereof 6-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location Balto Co

18 (a) Funeral director Sam'l R. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) JAN 15 1945 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945 to 6/13 1945 and that I last saw h[illegible] alive on 6/12 1945.

Immediate cause of death — Duration

Pulmonary Tuberculosis / Phthisis — 4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Safian
Address 275 Penna Date signed 6/14/45
M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G29824

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Helen Sellman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: eMale

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Walter Sellman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 15, 1868

8. AGE: Years 76 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Lawrence LeGourd
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Catherine Small
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Fannie Foxwell
(b) Address 1721 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Phillip Lamotrau
(b) Address 4510 Liberty Heights Ave.

19 (a) (b) Registrar

JUN 15 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13 1945, at 9A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1945, to 6/13 1945, and that I last saw h[illegible] alive on 6/11 1945.

Immediate cause of death Coronary Thrombosis

Duration Sudden

Due to Arteriosclerotic Cardio-Vascular Renal Disease.

Duration Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.

Address 1806 E. Preston Date signed 6/14/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29825 Baby boy Wade

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registration No. G29825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6316 Boston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Cecil Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-45 6/2/45

8. AGE: Years	Months	Days	If less than one day
		9 days	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Raymond Wade
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Bessie Wade
15. Birthplace W. Va.

16 (a) Informant mother - Bessie Wade
(b) Address 6316 Boston St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 15 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1945, to June 10 1945, and that I last saw him alive on June 10 1945.

Immediate cause of death	Duration
Respiratory failure	7 days
Due to Premature - (34 wks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Square Hosp Date signed 6/7/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G29826

G29826 CERTIFICATE OF DEATH 170D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. #9 Box 518 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Della Prince

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Femal	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
42	-	.	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Archie Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Mary
15. Birthplace Va

16 (a) Informant Clifton Prince
(b) Address Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (month) (day) (year)
(c) Cemetery or crematory Shuppel
Location Bel Kenvelle Va

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.
(c) JUN 15 1945 Huntington Williams, M.D. (Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1945 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple hemorrhages into the corpus callosum with necrosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-7-45 at 8:30 P.M. A.D. Co.
(b) Where did injury occur? Belle Grove Road
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by motor cycle

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 6-12-45

VS 151

G29827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G29827 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 140 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 S. Paca St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel E Conner

3 (b) If veteran, name war No

3 (c) Social Security Account No. 215-12-0108

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Lena E. Conner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1883

8. AGE: Years 61 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation U. S. Auxiliary M. M.

11. Industry or business Electric Fuction Co.

FATHER 12. Name Nicholas Conner

13. Birthplace Fort Savoy. Md

MOTHER 14. Maiden Name Mary Shorrett

15. Birthplace Fort Savoy. Md

16 (a) Informant Mrs Loretta Constable

(b) Address 1109 S Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Balto Co

18 (a) Funeral director A. Howard Evans

(b) Address 1400 Edmondson Ave

19 (a) (Date received by Registrar) (b) Registrar

JUN 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945, to June 15 1945, and that I last saw him alive on June 9 1945.

Immediate cause of death	Duration
Myocarditis	
Due to Cardiac Dilitation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Morley Hoag M. D.

Address 729 W Mulberry St Date signed June 15/45

G29828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G29828

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 TOONE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-6
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 TOONE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: FREDERICK FROHM

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 21 1863

8. AGE: Years 82 | Months 1 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace ENGLAND
(Town, county, and state)

10. Usual Occupation STEVEDORE

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace ENGLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ENGLAND

16 (a) Informant MARY KAMMERMAYER (FRIEND)
(b) Address 3304 TOONE ST.

17 (a) BURIAL (b) Date thereof JUNE 16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeder Co.
(b) Address 403 E. WOLFE ST.

19 (a) ... (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

JUN 16 1945
VS-150

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH JUNE 14 1945, at 2/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1945 to 6/14 1945, and that I last saw h[illegible] alive on 6/13 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Artero Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? [illegible] while at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 633 S. Conkling Date signed 6/15/45

X

G29829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G29829

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lauer (Joseph Theodore)
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced~~
6 (b) Name of husband or wife none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 13/45
8. AGE: Years | Months | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Joseph J. Lauer
13. Birthplace Baltimore
MOTHER 14. Maiden Name Jennie Romeo
15. Birthplace Baltimore
16 (a) Informant Joseph J. Lauer
(b) Address 2601 Orleans St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16/45 (month) (day) (year)
(c) Cemetery or crematory Mowland Mem Pk
Location Baltimore
18 (a) Funeral director Philip Howard Sons
(b) Address 2024 Orleans St
19 (a) JUN 16 1945 (Date rec'd by registrar) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 3 10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945 to June 15 1945 and that I last saw him alive on June 15 1945
Immediate cause of death Atelectasis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. M. Bacon Jr. M. D.
Address St. Joseph's Hospital Date signed 6-16-45

VS 150

G29830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

X V G29830

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calhoun St
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1853

8. AGE: Years 91 | Months 10 | Days 1 | If less than one day: hr. min.

9. Birthplace Carroll County
(Town, county, and state)

10. Usual Occupation farmer

11. Industry or business

FATHER
12. Name Joshua Wilson
13. Birthplace Carroll County

MOTHER
14. Maiden Name Mary Griffey
15. Birthplace Sykesville Md

16 (a) Informant Franklin Square Hosp.
(b) Address Balto. Md.

17 (a) Burials (b) Date thereof June 19, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakland Cem.
Location Carroll Co., Md.

18 (a) Funeral director C. Harry Weer
(b) Address Sykesville, Md.

19 (a) JUN 16 1945 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1945 at 11.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1945 to 6-15 1945
and that I last saw him alive on 6-15 1945

Immediate cause of death carcinoma

Due to Carcinomatosis (origin unknown)

Due to

Other Conditions 0

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 0

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Kezerian M. D.
Address Franklin Sq. Hosp Date signed 6-15-45

X

G29831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G29831

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto
(b) Street address 1027 S Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maud Insey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife Willie Insey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1903
8. AGE: Years 42 | Months | Days | If less than one day hr. min.
9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Housework
11. Industry or business Private work

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Willie Gross
(b) Address 1027 S. Sharp St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balt City
18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 N Monty
19 JUN 16 1945 Date rec'd by Local Reg. Interim for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12-1945, at 2P M
21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945, to June 12 1945, and that I last saw he alive on June 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry C Carper M. D.
Address 1016 S Sharp St Date signed 6-14-45

G29832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G29832 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General 2516
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 Grinden Ave.
(If rural give location)
(e) Citizen of foreign country? Grinden (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn F. Sledge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1939

8. AGE: Years	Months	Days	If less than one day
6	-	28	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George Sledge

13. Birthplace N.C.

MOTHER 14. Maiden Name Pinkie Jones

15. Birthplace N C

16 (a) Informant George Sledge

(b) Address 1338 Grinden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Q. A. Co Md

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W Montgomery St

19 (a) JUN 16 1945 (Date rec'd by registrar) Interring for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945 at 5:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to

Other Conditions Burned over thirty Grates Thymic lymphaticus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6/13/45 at 2 P. 25/6 M.

(b) Where did injury occur? Sun St. near Beth. Ramp

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by train

23. Signature Howard J. Shedden M.D.
Medical Examiner.

Date signed 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

G29833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29833 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 Edmondson Ave.
(c) Hospital or institution:
--
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County **
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle F.Jay

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wht.	Widow

6 (b) Name of husband or wife: Charles E.Jay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1869

8. AGE: Years	Months	Days	If less than one day
76	2	22	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: House-wife
11. Industry or business

FATHER
12. Name: Henry Fleming
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Katherine J.Key
(b) Address: 2627 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1945 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: Robert S.Little
(b) Address: 2700 Edmondson Ave.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

vs JUN 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to June 14 1945 and that I last saw her alive on June 14 1945

Immediate cause of death: Arteriosclerosis. Cerebral Hemorrhage — Duration: 5 yrs. & Da.

Due to: Cardiac Asthenia — Duration: 2 Da.

Due to: .....

Other Conditions: .....

(Include pregnancy within 3 months of death)

Date of operation: .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. G. Williams M. D.
Address 120 St Paul St Date signed June 15/45

Huntington Williams, M.D.

X

G29834 ✓ G29834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 N. Eden st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. Eden st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Preston Johnson

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business at Home

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Preston Johnson

(b) Address 300 N. Eden st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Pleasant Ave

19 (a) (Local registrar) (b) Huntington Williams Mott (Registrar)

JUN 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11-1945 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11-1945 to 6-11-1945 and that I last saw deceased alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 10

Due to: Cerebral Apoplexy

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. LeRoy Lewis, M.D.

Address 1420 E Chase Date signed 6-12-45

X

G29835 ✓ G29835

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 N. Central ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Central ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Crawford Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-1897

8. AGE: Years 47 Months 10 Days - If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Thomas Jefferson

13. Birthplace Va

14. Maiden Name Susie ?

15. Birthplace

16 (a) Informant Crawford Allen

(b) Address 1017 N. Central ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Blankley ave

19 (a) [illegible] (b) Hunting for Williams

JUN 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12-45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1945 to 6-12-45.
and that I last saw her alive on 6-12-1945.

Immediate cause of death Bronchio-Pneumonia | Duration 12 days

Due to Fibroid Tuberculosis | 8 wks

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.

Address 1327 N. Central ave Date signed 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

G29836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/93) G29836 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 W. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah B. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Augustus D. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1878

8. AGE: Years 66 67 | Months 5 | Days .24 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Gundy
13. Birthplace Va

MOTHER
14. Maiden Name Easter Kennedy
15. Birthplace Va

16 (a) Informant Lucy Gundy
(b) Address 1730 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley and Huntingtown Williams, Md

19 (a) JUN 16 1945 (Date rec'd by registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/45 19..., at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1944 to 6/10 1945; that I last saw h e alive on 6/10 1945

Immediate cause of death Cardiac Asthma — Duration 24 Months

Due to Hypertension Cardiac Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redkey, M.D.
Address 426 N. Pulaski Date signed 6/14/45

X

G29837 G29837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution:

15.6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Ellamont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

5.15

3 (a) FULL NAME Daniel Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Harris Shapiro
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie ?
15. Birthplace Russia

16 (a) Informant Norman Shapiro
(b) Address 5745 Jonquil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cemetery
Location Philadelphia Pa

18 (a) Funeral director Sol Levinson & Bros
Address 1124-1126 W North Ave
(b) Huntington Williams, M.D.

JUN 16 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945 to 6-15 1945, and that I last saw h[illegible] alive on 6-15 1945

Immediate cause of death: Broncho pneumonia.
Asterio sclerosis — Duration

Due to

Due to

Other Conditions Parkinsons disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levinson
Address 3400 Kilton Rd Date signed 6/15/45

VS 150

G29838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29838 Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 858 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Dantzic

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Myer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Abraham Aronchtm
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Sol Dantzic & Bros
(b) Address 858 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUN 16 1945 (b) Huntington (Registered by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

9.15

20. DATE OF DEATH June 15 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1943 to June 15 1945 and that I last saw h[illegible] alive on June 15 1945

Immediate cause of death Bronchopneumonia — Duration 3-4 day
Due to Parkinsonian Disease — 5 yrs (?)
Due to Generalized Arteriosclerosis — 3
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip J. Lerner
Address 2401 W. North Ave. Date signed 6/16/45

G29839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29839 Registered No. 117a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4188 Oldham St
(c) Hospital or institution: Md Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John William McNiell Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-3722

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 8 1869

8. AGE: Years 56 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Line Operator

11. Industry or business Continental Can Co

FATHER 12. Name John McNeill

13. Birthplace Balto

MOTHER 14. Maiden Name Katherine [redacted]

15. Birthplace Baltimore

16 (a) Informant Geo B Schatzo Schneider

(b) Address 418 S Oldham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address [illegible] Huntington Ave, Md

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150

JUN 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1945, at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1945, to 6-15 1945, and that I last saw him alive on 6-14 1945.

Immediate cause of death Lobar Pneumonia — Duration .....

Due to ..... — .....

Due to ..... — .....

Other Conditions Pulmonary Edema, — .....

(Include pregnancy within 3 months of death)

Date of operation 6-7-1945

Major findings of operation: Perforated Peptic ulcer

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Louis "Kalter" M. D.

Address Md. Gen. Hospital Date signed 6-N-45

G298-0

472694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G298-0

92B Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 953 N. Chester St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Alice Osswinkle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-6-18.

8. AGE: Years	Months	Days	If less than one day
27	2	7	.....hr. .....min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Home-work.
11. Industry or business

FATHER
12. Name Pearce Standcliffe
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Treisler
15. Birthplace Baltimore

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. Lillian St. Huntington Williams

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

JUN 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 10. P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945, to June 13 1945, and that I last saw h[illegible] alive on June 13 1945,

Immediate cause of death	Duration
Acute pulmonary edema	
Shock	
Due to Cardiac failure	2 hrs
Rheumatic heart disease	
With mitral stenosis & insufficiency	
Other Conditions Interventricular septal defect	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

(Signature) William T. Dixon
(Address) Johns Hopkins Hospital Date signed 6/15/45

G29841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G29841 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Middlebury - Box 179
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Donna Marie Eltan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Thomas R. Eltan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/1889

8. AGE: Years 55 | Months 11 | Days 27 | If less than one day hr. — min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Fuedel
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Blobers
15. Birthplace Austria

16 (a) Informant Patient
(b) Address

17 (a) Burial (b) Date thereof June 15
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Nat
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

19 (a) JUN 16 1945 (b) Huntington Williams
Date received by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1945, at 5 15/24 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945, to June 15 1945, and that I last saw h alive on June 14 1945.

Immediate cause of death Cerebral embolism — Duration 2 hrs

Due to Thrombophlebitis — Duration 2 wks

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Daty M. D.
Address Church Home & Hosp. Date signed 6-15-45

G29842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 937 G29842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2253 McElderry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2253 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas Serio

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/10/1870

8. AGE: Years	Months	Days	If less than one day
75	2	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Fruit dealer
11. Industry or business

FATHER
12. Name Ignatius Serio
13. Birthplace Italy

MOTHER
14. Maiden Name Dont Know
15. Birthplace Italy

16 (a) Informant Ignatius Serio
(b) Address 511 N. Fremont

17 (a) Burial (b) Date thereof June 19 (months) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. Orleans St.

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 19 45, at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mussina M.D.
Medical Examiner.
Date signed June 15, 1945

G29843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56a

Registered No. G29843

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1955 Perlman Place
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Clara E. Cahill

3 (b) If veteran, name war —

3 (c) Social Security Account No. .....

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, widowed, or ~~divorced~~: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21st 1880

8. AGE: Years 65 | Months 2 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Charles Cahill
13. Birthplace Md

MOTHER — 14. Maiden Name Catherine Deutenberger
15. Birthplace Md

16 (a) Informant Mrs Mary Zahrowthi
(b) Address 2124 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18th 1945 (month) (day) (year)

(c) Cemetery or crematory Mountanda
Location Taylor Ave

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave.

19 6-16-1945 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14 1945, at 9:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1945 to 6-14 1945, and that I last saw her alive on 6-13 1945.

Immediate cause of death ..... Duration
Acute heart failure .....
Due to ....
....
Due to ....
....
Other Conditions Dry gangrene, left foot .....
(Include pregnancy within 3 months of death)
Date of operation 5-21-1945 .....
Major findings of operation: Bilateral Multilocular Ovarian cysts .....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [illegible] M. D.
Address Md. Gen. Hospital Date signed 6-14-1945

VS 150

G29844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G29844 Registered No. (new)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 S PACA ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2671 WILKINS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD J. WISE

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-16-6539

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ELEANORE WISE

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) JULY 6 1888

8. AGE: Years 56 | Months 11 | Days 9 | If less than one day hr. min. 1889

9. Birthplace BALTO (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business BETHLEHEM STEEL

FATHER 12. Name JOHN WISE

13. Birthplace BALTO MD

MOTHER 14. Maiden Name BRIDGET CURRAN

15. Birthplace BALTO MD

16 (a) Informant ELEANORE WISE

(b) Address 2671 WILKINS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS CEM

Location A A Co

18 (a) Funeral director Bernard C Hahn

(b) Address 121 E West St

19 (a) (b) Huntington Williams, M.D. Registrar

JUN 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 15 1945 at 10 15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1945 to 6-15 1945. and that I last saw him alive on 6-15 1945

Immediate cause of death	Duration
Coronary Thrombosis	1da
Due to Coronary Disease	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H Lawrence M. D.

Address 719 Washington Blvd Date signed 6/16/45

G29845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G29845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address
(c) Hospital or institution South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 10 a. 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 850 Reinhart Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1929

8. AGE: Years 15 | Months 10 | Days 9 2 | If less than one day 1 hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Walter M. Warner
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Lynfella Morgan
15. Birthplace Petersburg Va.

16 (a) Informant Walter M. Warner
(b) Address 850 Reinhart Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19 1945 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Baltimore County

18 (a) Funeral director Joseph A. Ripley
(b) Address 410 N. Mount Street.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D. Registrar

JUN 16 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945 at 4:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4 P. M 6-14-45-25/6
(b) Where did injury occur? Arundel Sand & Gravel Co. Magnolia Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Drowning.

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed June 15 1945

X

G29846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29846 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 Stirling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) xyr

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Raeford N. C. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reddick Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Margaret Watson

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) June 29 1862

8. AGE: Years	Months	Days	If less than one day
283	11	16	hr. min.

9. Birthplace Raeford N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Adam Watson
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Gilchrist
15. Birthplace N. C.

16 (a) Informant Margaret Watson
(b) Address 623 Stirling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18th 1945 (month) (day) (year)
(c) Cemetery or crematory Mountain Grove
Location N. C.

18 (a) Funeral director Bryant & Inamis & Wright
(b) Address 1219 Druid Hill Ave

19 (a) JUN 16 1945 (Date rec'd by registrar) Buried in Williamsburg, Mass

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 June 1945 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 June 1945 to 15 June 1945 and that I last saw h. M. alive on 12 June 45

Immediate cause of death Heart Failure. — Duration

Due to Myocardial degeneration

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert E. Brunwald M. D.

Address 121 Gisgault Date signed 15 June

G29847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G29847 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4021 Roland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4021 Roland Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Karr Blakeney

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-2549

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine A. Blakeney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5-1882

8. AGE: Years 62 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Superintendent
11. Industry or business Gpi State Bottling Co.

FATHER
12. Name Charles H Blakeney
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Karr
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Catherine A. Blakeney
(b) Address 4021 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Durgin Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by local registrar) (b) Huntington, West Virginia, Md.

JUN 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1945, to June 15 1945.
And that I last saw him alive on June 15 1945.

	Duration
Immediate cause of death: Carcinoma Left Lung	3 mo
Due to: Metastasis Left Cerebrum	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. Mclean M. D.
Address 617 W. 40th Date signed 6/16/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29848 Registered No. 1117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N. Broadway & Fairmount
(b) Street address [redacted]
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr John G Callan.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna Callan.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 3 1893
8. AGE: Years 51 | Months 8 | Days 12 | If less than one day ____ hr. ____ min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: City Hall Employee
11. Industry or business:

FATHER
12. Name: John Callan
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Madaleine Faye
15. Birthplace: New York N.Y.

16 (a) Informant: Hospital admin
(b) Address: Record.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/16/45 (month) (day) (year)
(c) Cemetery or crematory: H. Redeemer
Location: Belair Rd.
18 (a) Funeral director: W. W. E. Dipple Sons
(b) Address: 410 N. Howard & Lanvale Sts.
19 (a) (Date received by Registrar) (b) Registrar
JUN 16 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 4 45 M
21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1945, to 6-15 1945, and that I last saw him alive on 6-15 1945.

	Duration
Immediate cause of death: Cerebral hemorrhage.	[redacted] 7 days
Due to: Generalized arteriosclerosis.	
Due to:	
Other Conditions: Post op pneumonia.	

(Include pregnancy within 3 months of death)
Date of operation 6-6-45
Major findings of operation: Perforated peptic ulcer.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Robert D Daly M. D.
Address: Church Home & Hosp. Date signed 6-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G29849
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTUS D. HOLBROOK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Gertrude M. Holbrook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1872

8. AGE: Years 72 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation: Merchant
11. Industry or business: Self

FATHER
12. Name: - Holbrook
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mr. Marion A. Holbrook
(b) Address: 2816 W. Lafayette Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

JUN 16 1945 (Date Received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to June 14 1945 and that I last saw h[illegible] alive on June 14 1945.

	Duration
Immediate cause of death: Acute Pulmonary Edema	1 hour
Due to: Hypertension C-V-D	2 years
Due to: Coronary Atherosclerosis	2 years
Due to:	
Other Conditions: None	

(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Ray Alaman M. D.
Address: 1201 Eutaw Pl. Date signed 6-16-45

VS 150

G29850 G29850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Laurel Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Laurel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELEANOR W. KUHLEMANN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry S. Kuhlemann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1857

8. AGE: Years 87 | Months 10 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Frederick Dreyer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Adelaide Radecke
15. Birthplace Germany

16 (a) Informant Mr. Henry Kuhlemann
(b) Address 4801 Laurel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/45 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Violetville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to June 14 1945, and that I last saw her alive on June 14 1945.

Immediate cause of death: (a) Senile Degeneration — Duration 6 mos.
Due to
Due to Softening of Brain — 5 yr.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John A. Evans M. D.
Address 6 E. Lexington St. Date signed

G29851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

G29851 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3956 Wilsby Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3956 Wilsby Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph R. Schuler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1892

8. AGE: Years 52 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name ? Schuler
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Irene Schuler
(b) Address 3956 Wilsby Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem
Location Taylor Ave

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) JUN 16 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 1:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1945 to 6/9 1945. and that I last saw him alive on 6/9 1945

Immediate cause of death Rupture of [redacted] aneurysm of Aorta

Due to [redacted]

Due to

Other Conditions See records of Dr. Wood, Johns Hopkins Hosp.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
15-20 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Greyton M.D.
Address 3963 Greenmount Ave. Date signed 6/14/45

VS 150

G29852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G29852 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 S Bouldin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 S Bouldin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Blair

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, ~~married~~, widowed, or divorced Widow

6 (b) Name of ~~husband~~ or ~~wife~~ Fredrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1873

8. AGE: Years 72 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name B. Collin

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Ryan

15. Birthplace Ireland

16 (a) Informant Irene Whittaker

(b) Address 339 S Bouldin St

17 (a) Burial (b) Date thereof Jun 18-45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Road

18 (a) Funeral director John C Mosan

(b) Address 3000 E Baltimore St

19 (a) (Date received by registrar) JUN 16 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to June 15 1945 and that I last saw h[er] alive on June 9 1945

Immediate cause of death	Duration
Arteriosclerotic Cardiac Valvular Renal Disease	?
Due to	
Due to	
Other Conditions Anemia	12 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Alex E. Sikorsky M. D.

Address 2939 Fleetwood Date signed 6/15/45

G29853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G29853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St.
(c) Hospital or institution: Avon Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3232 Abell Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Matilda Finney Gregg

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband William F. Gregg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1859

8. AGE: Years 86 | Months 2 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Wallace
13. Birthplace Scotland

MOTHER
14. Maiden Name Sarah MacNair
15. Birthplace Pennsylvania

16 (a) Informant Madeline Gregg
(b) Address 3232 Abell Ave

17 (a) Cremation (b) Date thereof 6/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUN 16 1945 (Registrar's signature) Barrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to June 15 1945 and that I last saw her alive on June 15 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Diabetic Gangrene of right foot & infection	
Due to Diabetes Mellitus	
Other Conditions Generalized Arterio-sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchiyah Spraguine M.D.
Address U. M. H. Date signed 6-15-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1562 Abbottston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1562 Abbottston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida C George

3 (b) If veteran, name war: M
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wilhome
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 13. 1871

8. AGE: Years 74 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: August A Brandt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Carrie McCulloh
(b) Address: 1562 Abbottston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1212 St Paul St.

19 (a) JUN 16 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 1 30/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/45 to 6/15/45, and that I last saw h[illegible] alive on 6/15/45

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	1 yr
Due to Hypertension	
Other Conditions Uremia, Bronchopneumonia	6 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Herrmann M. D.
Address 1710 E 33rd St Date signed 6/17/45

G29855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G29855 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Ridgewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. V. Martenet

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Wid

6 (b) Name of husband or wife: Oscar C. Martenet Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1859

8. AGE: Years 85 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Walker
13. Birthplace Md

MOTHER 14. Maiden Name Emily Ford
15. Birthplace Md

16 (a) Informant Maynie D Martenet
(b) Address 4102 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

19 (a) JUN 16 1945 Huntington-Williams M.D.
Date received by Local Registrar (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945, to June 17 1945; and that I last saw h.e alive on June 15 1945.

Immediate cause of death	Duration
Myocarditis, Chronic Passively C.a of Gall Bladder	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dorothy Queen M. D.
Address Med Arts Date signed 6-15-45

X

G29856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29856 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. Gaol Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Otts Convalescent Home
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Jennie Rahn

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry N. Rahn

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 10th 1862

8. AGE: Years: 83 | Months: 5 | Days: 5 | If less than one day: .....hr. .....min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Ephraim Yingling
13. Birthplace Carroll Co Md.

MOTHER
14. Maiden Name Lucinda Hornberger
15. Birthplace Carroll Co. Md.

16 (a) Informant E. W. Rahn
(b) Address 20 Maple Drive - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45
(month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) JUN 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1945 at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1945 to 6-15 1945 and that I last saw her alive on 6-15 1945.

Immediate cause of death: Congestive heart failure — Duration .....

Due to: Arteriosclerotic cardiovascular disease — Duration .....

Due to..... — Duration .....

Other Conditions..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Geo. W. Gallion M. D.
Address Md. Gen. Hospital Date signed 6-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G29857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Harman Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph A. Taylor

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Adelaide

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1904

8. AGE: Years 40 | Months 7 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Mill Worker

11. Industry or business

FATHER
12. Name John
13. Birthplace Illinois

MOTHER
14. Maiden Name Blanche
15. Birthplace Illinois

16 (a) Informant Adelaide Taylor
(b) Address 702 Harman Rd - Morrell Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Carmel
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St

19 JUN 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945, to June 15 1945, and that I last saw him alive on June 15 1945.

Immediate cause of death	Duration
Generalized Peritonitis	3
Due to Ruptured Peptic ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/12/45

Major findings of operation: Ruptured peptic ulcer - early peritonitis

of autopsy: Generalized peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jose A. Alvarez de Chevedeno M. D.

Address Date signed

G29858

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29858 Registered No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Newton ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard H. Heidemann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single —

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1929

8. AGE: Years	Months	Days	If less than one day
15	7	13	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business Public School

FATHER
12. Name Arthur Heidemann
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Nealie M. Brown
15. Birthplace Md

16 (a) Informant Arthur P. Heidemann
(b) Address 4107 Newton Ave

17 (a) Burial (b) Date thereof 6/19/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JUN 16 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14- 1945 at 11 45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2715
(a) Date of injury 6-14-45 at P. M.
(b) Where did injury occur? Meadowbrook Swimming Pool
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 6-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29859 Hilbert G29859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 39c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount
(c) Hospital or institution:
Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Van Buren
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hebert R Reamstan

3 (b) If veteran, name war W

3 (c) Social Security Account No. 213-07-0457

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elenor Reamstan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1915

8. AGE: Years 29 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Dundalk, Maryland
(Town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business

FATHER
12. Name Paul Reamstan
13. Birthplace St Paul's - Eastern Shore, Md.

MOTHER
14. Maiden Name Evena Egeberg
15. Birthplace Iguanaw Pt, Maryland

16 (a) Informant Mrs P Reamstan
(b) Address Dundalk Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 2470 Penna Ave

19 JUN 16 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 5 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1945 to June 14 1945, and that I last saw him alive on June 14, 1945

Immediate cause of death Rocky Mountain Spotted Fever — Duration 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rocky Mountain Spotted Fever

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert D Darby M. D.
Address Church Home Hosp Date signed 6-16-45

(over)

G29860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

✓ G29860
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: St Joseph's Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr (Leonard) Feola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 - 1893

8. AGE: Years	Months	Days	If less than one day
52		10	hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Tavern Keeper

11. Industry or business

FATHER 12. Name John Feola
13. Birthplace Italy

MOTHER 14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Anthony Feola
(b) Address 4614 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John P Connelly
(b) Address 128 Eastern ave. Balto 2

19 (a) Date received JUN 17 1945 (registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1945, to 6-15 1945
and that I last saw h[illegible] alive on 6-14 1945

Immediate cause of death Cardiac failure

Due to Rheumatic heart disease (inactive)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 6-15-45

VS 150

G29801 ✓ G29801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 C

Registered No. _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 W. Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie S. A. Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife David M. Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	30	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Deise
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret A. S. Winter
15. Birthplace Baltimore Md.

16 (a) Informant David M. Shipley
(b) Address 2813 W. Garrison Ave

17 (a) Burial (b) Date thereof 6-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Lossing Byers
(b) Address 5005 Park Heights Ave.

19 JUN 17 1945 (b) Huntington Williamsport, Md.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16-45 19___, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 16 1945, and that I last saw her alive on June 16 19 45

Immediate cause of death	Duration
Cerebral embolism -	
Due to Rheumatic Heart Disease	2 days
Due to (a) Mitral Stenosis	30 yrs.
(b) Aortic Insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton E. Lowman M. D.
Address 5013 Park Heights Ave Date signed 6-18-45

X

G29862

HEP - 15691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G29862

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-0 - 3

(e) Length of stay in Baltimore (yrs., mos., or days) 13 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 307 N. Broadway
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Peter Joseph Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	7	hr. min.

9. Birthplace San Francisco, Calif.
(Town, county, and state)

10. Usual Occupation Marble Setter

11. Industry or business

FATHER

12. Name Peter Cunningham

13. Birthplace Ireland

MOTHER

14. Maiden Name Delia Corbett

15. Birthplace Ireland

16 (a) Informant Baltimore City Hospital (Records)

(b) Address 4940 Eastern Ave.

17 (a) burial (b) Date thereof 6-22-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location San Francisco Calif.

18 (a) Funeral director A. Lee Oder

(b) Address 4644 York Rd.

19 (a) JUN 27 1945 Huntington Williams
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12, 1934, to 6-15, 1945, and that I last saw h im alive on 6-15, 1945.

Immediate cause of death Bronchopneumonia — Duration 10 days

Due to Pyaemia umbonis — 7

Due to Arteriosclerosis, generalized — 7

Other Conditions Pernicious anemia

Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. M. Phillips M. D.

Address Balt City Hosp Date signed 6-15-45

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G29863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G29863 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1727 Bank St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1727 Bank St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Pawlicki

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-6075

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 59 Months Days If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Ford Motor Co

FATHER

12. Name Antoni Czerwinski

13. Birthplace Poland

MOTHER

14. Maiden Name Czyszewski

15. Birthplace Poland

16 (a) Informant Martin Pawlicki

(b) Address 1727 Bank St

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof June 18/45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary

Location Baltimore

18 (a) Funeral director Fred W Czyszewski

(b) Address 1930 Eastern Ave.

19 (a) Filed (Date received by registrar) JUN 17 1945

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 1945 to June 15 1945, and that I last saw h alive on June 12 1945.

Immediate cause of death: Coronary occlusion

Due to: Right sided ? hemiplegia

Due to: Hypertension, vascular changes and interstitial nephritis

Other Conditions: Secondary anemia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration: 1 day; 1 mo; Several years; Several months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)

(e) Means of injury —

23. Signature G. F. Reis M. D.

Address 24 S. Broadway Date signed June 16/45

G29864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G29864 ✓

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3405 Shannon Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Yr

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3405 Shannon Drive

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) **FULL NAME** Dennis H. Dorsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ella A. Dorsey

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 5-1862

8. AGE: Years 83 | Months 4 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co.

(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Dennis H. Dorsey

13. Birthplace Ireland

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs Margaret Hooper

(b) Address 3405 Shannon Drive

17 (a) Burial (b) Date thereof June 19 45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto.

18 (a) Funeral director Philip Herring Sons

(b) Address 1024 Pleasant St

19 (a) Huntington Williams, M.R.

(Date received by registrar) Registrar

JUN 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945, to June 15 1945; and that I last saw h[illegible] alive on June 15 1945.

Immediate cause of death	Duration
Chronic Myocarditis	
Chronic Nephritis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Joseph Tourkey M. D.

Address 4411 Edmondson Ave Date signed 6/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29865 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 3301 Pierce Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Shapiro (Sarah Florence Schapiro)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Ruth (Town, county, and state) Newcastle

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Jacobs

13. Birthplace Ruth

MOTHER 14. Maiden Name Cecelia —

15. Birthplace Ruth

16 (a) Informant Herman Schapiro

(b) Address 3301 Pierce Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-45 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Blvd

18 (a) Funeral director Jacob Heyman Inc

(b) Address 1939 E. Baltimore St

19 (a) (b) Registrar

JUN 17 1945 Date rec'd by registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1945, to 6-15 1945, and that I last saw h[illegible] alive on 6-15 1945.

Immediate cause of death Myocardial infarction

Due to Coronary thrombosis

Due to Arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herman D. Herman M.D.

Address Sinai Hospital Date signed 6/17/45

G29866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G29866
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 85 | Months 4 | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Charles Bannon
13. Birthplace

MOTHER 14. Maiden Name Anna Curley
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b) Registrar
Date rec'd by registrar JUN 17 1945
Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 15 1945, and that I last saw h alive on June 14 1945.

Immediate cause of death	Duration
Edema Lungs	1 Day
Due to Cerebral Hemorrhage	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Gell Hall M. D.
Address 1631 E Northan Date signed 6/16/45

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1 2 G29867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121 B

G29867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Lifelong

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 242 N Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Siwatka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1899

8. AGE: Years 46 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Cigar maker

11. Industry or business

FATHER 12. Name Frank Siwatka
13. Birthplace Bohemia

MOTHER 14. Maiden Name Emanstasia Vlk
15. Birthplace Bohemia

16 (a) Informant Ethel Schmidt
(b) Address 2424 Oakland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Borchelas
(b) Address 900 N Chester St

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1945 to 6/14 1945, and that I last saw her alive on 6/14 1945.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

G29868 G29868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Mt. Holly St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frank Leslie Timanus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha M. Timanus
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) April 26, 1891

8. AGE:	Years	Months	Days	If less than one day
	54	1	19	hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Realtor
11. Industry or business Real Estate

FATHER
12. Name Theodore Leslie Timanus
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Florence J. White
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Bertha Timanus
(b) Address 2212 Mt. Holly St.

17 (a) Burial (b) Date thereof June 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Hampstead, Md.

18 (a) Funeral director Phillip Lamonaco
(b) Address 4510 Liberty Heights Ave.

19 (a) ..... (b) Huntington Williams, M.D.
(Date rec'd by registrar)

JUN 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 3.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1944 to June 15 1945 and that I last saw him alive on June 15 1945.

Immediate cause of death Cardio vascular disease — Duration about 6 mo

Due to Arteriosclerosis Hypertension — ? ? chart

Due to Acute parenchymatous nephritis — 3 mo

Other Conditions Myocarditis — 6 mo duration.
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify in case of place)
(e) Means of injury

23. Signature Walter Stubblett M. D.
Address 2220 Garrison Blvd. Date signed

G29869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1122a

G29869
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND 33RD STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 W. FAIRMOUNT AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. MYRTLE RUPPERT (MRS. HENRY LOUIS)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MR. HENRY L. RUPPERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 23, 1894

8. AGE: Years 50 | Months 11 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name MR. WILLIAM W. ECKHARDT
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ELIZABETH WELTNER
15. Birthplace BALTIMORE, MD.

16 (a) Informant PT. BEFORE DEATH
(b) Address —

17 (a) Burial
(b) Date thereof 6-18-45
(month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md

18 (a) Funeral director Geo. A. Bailey
(b) Address Dulton & Forsyth

1945 Date received by registrar JUN 17 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 15, 1945, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1945 to 6/15 1945, and that I last saw h alive on 6/15 1945.

Immediate cause of death ACUTE CARDIAC FAILURE — Duration ...

Due to PULMONARY EDEMA — Duration ...

Due to ... — Duration ...

Other Conditions P.O. INCARCERATED HERNIA — Duration ...
(Include pregnancy within 3 months of death)

Date of operation 6/15/45

Major findings of operation: INCARCERATED HERNIA.

Autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury ...

23. Signature Hyman Primakoff
Address Temple Gardens Date signed 6/15/45
× Primakoff

G29870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29870 Registered No. 121

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Finksburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1933

8. AGE: Years 12 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Carroll County Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Miller
13. Birthplace Carroll County Md

MOTHER
14. Maiden Name Mary Ruth Miller
15. Birthplace Carroll County Md

16 (a) Informant Ruth Spencer
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Wesley Cem.
Location Carroll County Md

18 (a) Funeral director Francis J. Reese
(b) Address Westminster Md

JUN 17 1945 (Date received by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ June 16 1945 to 19 ; and that I last saw h e y alive on June 16 1945

Immediate cause of death Resp. failure — Duration

Due to Pulmonary edema

Due to Rt. heart failure — Rheumatic C.V.D.

Other Conditions Post operative (19 hrs.) appendectomy
(Include pregnancy within 3 months of death)

Date of operation 6/15/45

Major findings of operation: Acute catarrhal appendicitis

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard J. Trabaud Jr. M.D.
Address Univ. Hospital Date signed 6/16/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

G29871 G29871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Canterbury Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Canterbury Rd.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME WILLIAM M. KERR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 22, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	23	hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Self

FATHER
12. Name Robert J. Kerr
13. Birthplace Conshohocken, Pa.

MOTHER
14. Maiden Name Mary A. Norwood
15. Birthplace Balto., Md.

16 (a) Informant Miss Helen W. Kerr
(b) Address 3903 Canterbury Rd.

17 (a) Burial (b) Date thereof 6/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 17 1945 (Signature of registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945, at 3:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to June 15 1945 and that I last saw h/M alive on June 14 1945.

Immediate cause of death Coronary Thrombosis, Mitral & Aortic Insufficiency

Due to Not known Bronchopneumonia

Due to Arteriosclerosis

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration
Not known
1 wk.
Not known
Not known

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature Wallace A. Linton M.D.
Address 1500 Rolworth Rd. Date signed 6/16/45

VS 150

92a

G29872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

G29872
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S. Collins Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar D. Holland

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice E. Holland

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1886

8. AGE: Years: 58 | Months: 9 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Maryland (Montgomery Co.) (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Schenuit Rubber Co.

FATHER
12. Name: James Holland
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Johnson
15. Birthplace: Maryland

16 (a) Informant: Mrs. Alice E. Holland
(b) Address: 202 S. Collins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/19/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) Registrar

JUN 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1945 19... at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26, 1945 to May 16 1945 and that I last saw him alive on May 16 1945.

Immediate cause of death: Cardiac Failure — Duration:
Due to: Pulmonary Edema
Due to: Carcinoma of Panda Equina
Other Conditions: Generalized Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: Ca of Panda Equina
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. L. Peterson M. D.
Address: Date signed: 6/16/45

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

G29873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS MENTZER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elizabeth Mentzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1856

8. AGE: Years	Months	Days	If less than one day
89	4	14	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Nora E. Keefer
(b) Address 1618 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945 at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to June 15 1945, and that I last saw him alive on June 14 1945.

Immediate cause of death	Duration
Myocardial insufficiency	
Arteriosclerotic type heart disease with hypertension and coronary	
Due to Renal failure	
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. W. Michel M. D.
Address 290 Edmondson Ave Date signed June 17 45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G29874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29874 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3434 Chestnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3434 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie M. Chew.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow.

6 (b) Name of husband or wife Grant Chew.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1876

8. AGE: Years 68 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Indiana. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER 12. Name Frank Brown

13. Birthplace Maryland.

MOTHER 14. Maiden Name Alice Slater.

15. Birthplace Maryland.

16 (a) Informant Wm. R. Chew.

(b) Address 3434 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1945 (month) (day) (year)

(c) Cemetery or crematory Asbury

Location Reisterstown, Md

18 (a) Funeral director Cumowell & Donovan

(b) Address 3415-17 Chestnut Ave

JUN 18 1945 (Date rec'd by registrar) Huntington Williams Mfg Co

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 5:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945, to June 14 1945, and that I last saw h[illegible] alive on June 14 1945.

Immediate cause of death Myocardial insufficiency — Duration 3 hrs.

Due to Arteriosclerotic cardiac disease — Duration 2y

Due to — Duration

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible]

Address 3429 Chestnut Ave Date signed 6/16/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 629875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Or
(c) ~~Hospital or institution~~: Md School for Blind 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Md School for Blind (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia B. Morey

3 (b) If veteran, name war: M
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~or wife~~: George C. Morey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10th 1906

8. AGE: Years 38 | Months 10 | Days 6 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Elmer Murray Tiller
13. Birthplace Un Known

MOTHER
14. Maiden ~~Name~~ Beatrice F. "
15. Birthplace Columbus Ohio

16 (a) Informant George C. Morey
(b) Address Md. School for the Blind

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUN 18 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 12.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945, to June 16 1945 and that I last saw h[illegible] alive on June 12 1945

Immediate cause of death: Metastatic Carcinoma (Right Breast) — Duration: May 8 1932 Started 1st Treatment

Due to:

Due to:

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Green M.D.
Address 3009 Eastern Ave Baltimore 24 Maryland Date signed 6/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G29876

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3422 Berwick Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3422 Berwick Rd (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Arthur E Mentzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	M

6 (b) Name of husband or wife Rose M. Mentzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 7 1863

8. AGE: Years	Months	Days	If less than one day
82	2	9	hr. min.

9. Birthplace Randallstown Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Bertie Berkenkemper

(b) Address 3422 Berwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location

18 (a) Funeral director H. Cook Inc

(b) Address 717 St Paul St

19 JUN 18 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to June 16 1945 and that I last saw him alive on June 15 1945

Immediate cause of death Bronchopneumonia — Duration 2 Weeks

Due to Heart failure

Due to arteriosclerotic heart Disease — 25 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Forrest Wallerstein M. D.

Address 898 W 36th Date signed 6/17/45

G29877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G29877

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5615 Magnolia Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Duerling

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 1866

8. AGE: Years 78 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Truck Farmer

11. Industry or business

FATHER 12. Name Jacob Duerling

13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Wilkinson

15. Birthplace Falls Md

16 (a) Informant Laura Little

(b) Address 5610 Magnolia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Tilton & Son

(b) Address 1211 Eutaw St

19 JUN 18 1945 (b) Huntington Williams, M.D. (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 19 45 at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 19 45 to 6/17 19 45 and that I last saw him alive on 6/17 19 45

Immediate cause of death Cardio resp failure — Duration

Due to Coronary multiple thrombi — Duration

Due to Hypertrophy of bronchus — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 6/14

Major findings of operation: Etiology not found

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dr. A. M. Lumbrey M. D.

Address Sinai Hospital Date signed 6/17/45

G29878 | G29878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No. G29878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W. Fayette St.
(b) Street address 737 W. Fayette St.
(c) Hospital or institution:
4h
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Hettrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Adam Hettrick
13. Birthplace Germany

MOTHER
14. Maiden Name Johnson
15. Birthplace "

16 (a) Informant Louis Kircher
(b) Address 2809 Biswick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 6/19/45

(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Wilhom & Son
(b) Address 1219 E Pratt St

19 JUN 18 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 45 at 11:30 A. M

21. I certify that I took charge of the remains described above, held an Inquiry + Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 15, 1945.

G29879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91 ✓

G29879 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: University Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12dy

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County.....

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4138 Parkside Dr.
(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frederick W. Mihm

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of ~~husband~~ or wife: Sarah Mihm

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8 1881

8. AGE: Years: 64 | Months: 1 | Days: 8 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Andrew Mihm
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara Hochrentz
15. Birthplace: 4138 Parkside Drive

16 (a) Informant: Mrs. C. R. Fridy
(b) Address: 4138 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/20/45 (month) (day) (year)

(c) Cemetery or crematory: Parkwood
Location: Parkside Md

18 (a) Funeral director: Tillson & Son Inc
(b) Address: 1217 E Fort Ave

19 (a) Date received by local registrar: JUN 18 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at 6.59 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to June 16 1945, and that I last saw h.[illegible] alive on June 16 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to acute bacterial endocarditis	
Due to septicemia (staph.)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:.....

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)

(e) Means of injury.....

23. Signature M. Goldstein M.D.

Address Municipal Hosp. Date signed 6/16/45

X

G29880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. G29880

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Webster
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Bruce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17-1945

8. AGE: Years	Months	Days	If less than one day
-	6	22	hr. min.

9. Birthplace maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Bruce
13. Birthplace S. C.

MOTHER
14. Maiden Name mildred Hall
15. Birthplace md.

16 (a) Informant John Bruce
(b) Address 1309 Wibster Alley

17 (a) Burial (b) Date thereof 6-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penn Ave

19 JUN 18 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 17 1945, and that I last saw her alive on June 17 1945

Immediate cause of death	Duration
Respiratory failure	8 hrs
Due to Acidosis ; dehydration	24 hrs
Due to Infectious diarrhea	48 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address University Hospital Date signed 6/17/45

VS 150

G29881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

105

G29881 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Johnsow Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20 - 1918

8. AGE: Years 27 | Months 5 | Days 21 26 | If less than one day hr. min.

9. Birthplace maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John allen
13. Birthplace N C.

MOTHER
14. Maiden Name Blanch Chase
15. Birthplace md

16 (a) Informant Blanch allen
(b) Address 913 Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus memorial Pk
Location Baltimore md

18 (a) Funeral director William a. Jackson
(b) Address 916 Penn Ave

19 JUN 18 1945 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 15 1945, at 6 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 15 1945 to 6 - 15 1945
and that I last saw her alive on 6 - 15 1945

Immediate cause of death*	Duration
possible foreign body in throat	
Due to Edema of larynx	
Due to Laryngo spasm * Asphyxia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes (K.S.M.)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Junkin M. D.

Address Union Hosp Redwood & Greene Sts Date signed 6-15-45

VS 150 For B.H.B. Wm Kelly - by H. J. Mallis, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629882

HEP - 90293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 629882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 7- 26
(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Druid Hill Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Fisher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1867

8. AGE: Years 78 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Poke Rogers
13. Birthplace Virginia

MOTHER
14. Maiden Name Harriet ?
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto md

18 (a) Funeral director William A. Jackson
(b) Address 914 Penn ave

19 (a) JUN 18 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19, 1944, to June 15, 1945, and that I last saw her alive on June 15, 1945.

Immediate cause of death Coronary Thrombosis. — Duration 1 mo.

Due to

Due to

Other Conditions Mental confusion & complete disorientation. Organic brain syndrome. — Duration 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature

Address Date signed 6-6-45

VS 150

G29883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G29883

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4415 Wentworth Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Wentworth Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ackler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22. 1877

8. AGE: Years 67 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Wm F Ackler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret A Hughes
15. Birthplace Baltimore

16 (a) Informant Mrs Margaret Hufnagle
(b) Address 4415 Wentworth Road

17 (a) Burial (b) Date thereof June 18
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location City

18 (a) Funeral director Ulrich Funeral Chapel
(b) Address 2008 Orleans

19 (Signature and title) Huntington Williams, M.D.
JUN 18 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1945 at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to 6-15 1945, and that I last saw h alive on 6-14 1945.

Immediate cause of death: arteriosclerotic Cardio Vasc Renal Disease — Duration 10 mos.
Due to Chronic Myocarditis — 1 yr
Due to Chronic Interstitial Nephritis — Many
Other Conditions Cerrhosis Liver — 10 mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos H Abbott M. D.
Address 450 Fairfax Heights Road

Thos. H. Abbott 6-16-45 1314a

G29884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1602 Registered No. G29884

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Fenwick St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Fenwick Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7- 1945

8. AGE: Years | Months | Days | If less than one day 4 hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry ?
13. Birthplace

MOTHER
14. Maiden Name Bertha Page
15. Birthplace Balto Md.

16 (a) Informant Hosp Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 8 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Intracranial Hemorrhage.	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Wirth M. D.
Address University Hosp Date signed 6-9

JUN 15 1945 UNIVERSITY MEDICAL SCHOOL
JUN 18 1945 Huntington Williams M.D. Commissioner of Health

2-68

G29885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 Registered No. G29885

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 N. Wolfe st. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Morton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-5-03

8. AGE: Years	Months	Days	If less than one day
42	9	3	..... hr. ..... min.

9. Birthplace U.S. (Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER 12. Name John Morton
13. Birthplace ?

MOTHER 14. Maiden Name Ida Miller
15. Birthplace ?

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL JUN 15 1945

18 (a) Funeral director.....
(b) Address..... Commissioner of Health

19 (a) JUN 18 1945 (Signature) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1945 to 6-8 1945 and that I last saw [illegible] alive on 6-8 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Constrictive pericarditis probably tuberculous	
Due to	
Other Conditions Latent lues	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Alan G. Woods M.D.
Frederick M. Stacey Jr. M.D.

Address Johns Hopkins Hosp. Date signed 6/9/45

2.67 - 218

G29886

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G29886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Mayo (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name John Boston
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Thomas
15. Birthplace Maryland

16 (a) Informant.....
(b) Address.....

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL JUN 15 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 JUN 18 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1945, at 1155 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 12 1945, and that I last saw him alive on June 12 1945.

Immediate cause of death Intracranial hemorrhage — Duration .....

Due to..... — Duration .....

Due to..... — Duration .....

Other Conditions..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature M. D. Griffith M. D.
Address..... Date signed.....

2-66

G29887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83Q Registered No. G29887

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Spangler Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Spangler Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Morris

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Margaret Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 1875

8. AGE: Years	Months	Days	If less than one day
69	8	22	hr. min.

9. Birthplace Scranton Penna (Town, county, and state)
10. Usual Occupation Retired Coal Miner
11. Industry or business

FATHER
12. Name Evan Morris
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Wm. Carroll
(b) Address 1010 Spangler Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Albert L Hilty Jr
(b) Address 1606 N. Chester Street

19 JUN 18 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 10 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to June 1945 and that I last saw h[im] alive on June 15 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
due to Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter M. D.
Address 2237 Lake Ave Date signed 6/16/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 97

G29888 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 2 mo 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. Providence Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Margaret Mary Dolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1873

8. AGE: Years	Months	Days	If less than one day
71	9	16	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business —

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope Cemetery
Location Mount Hope Retreat, City

18 (a) Funeral director Stewart & Mowen Company
(b) Address 102 W. North Avenue, City

19 (a) JUN 18 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1944 to June 17 1945 and that I last saw h.e.r alive on June 17 1945.

Immediate cause of death	Duration
Circulatory Collapse	2 days
General Arteriosclerosis	2 yrs.
Due to	
Due to	
Other Conditions Psychosis with Arteriosclerosis (Include pregnancy within 3 months of death)	since admission

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D P Alagia M. D.
Address 33 N Jefferson St Date signed

X

G29889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G29889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Garrison Blvd
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 University Pkwy (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Laura McLellan (LAURA MacLELLAN)

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife Single
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 24 1849

8. AGE: Years 96 | Months 3 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Balt (Town, county, and state)

10. Usual Occupation [illegible]
11. Industry or business

FATHER
12. Name Rufus MacLellan
13. Birthplace probably Mass.

MOTHER
14. Maiden Name Annie Cronican
15. Birthplace probably Mass.

16 (a) Informant Mrs A. S. Levy (niece)
(b) Address 3430 University Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Steuart Hearse Co
(b) Address 101 W North Ave.

19 (a) JUN 19 1945 (Date rec'd by Local Reg.) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to June 14 1945; and that I last saw h[illegible] alive on June 14 1945.

Immediate cause of death: Myocarditis — Duration: 10 days
Due to
Due to
Other Conditions: Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Crain M. D.
Address 1612 Eutaw Pl Date signed

VS 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G29890 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital Dominitory
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Pacca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Mullins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Mullins

13. Birthplace Ala.

MOTHER 14. Maiden Name Alice —

15. Birthplace Ala.

16 (a) Informant Jos. Williams

(b) Address 2512 Pacca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director James A. Stavros

(b) Address 1442 Wolfe St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

JUN 18 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1945, at 9:45 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. B. Williams M.D. (Medical Examiner)

Date signed 6/17/45

G29891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

G29891E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave & Gwynn Oak
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Barron St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mathew Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Bl. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dora Reynolds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business

FATHER
12. Name Charles Reynolds
13. Birthplace Md.

MOTHER
14. Maiden Name Annabelle Ringgold
15. Birthplace Md.

16 (a) Informant Dora Reynolds
(b) Address 827 Penn St

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hagan
(b) Address 142 Westfield Ave

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150 JUN 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1945 at 6 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1945 to 6/16 1945 and that I last saw him alive on 6/16 1945.

Immediate cause of death Cardiac failure & pulmonary infarction

Due to Hypertension & Luetic aortitis

Due to Hypertensive cardiovascular renal disease

Other Conditions Uremia & Jaundice & pul. infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ~~Congestive~~

of autopsy: Congestive failure

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. R. Emig, M.D.

Address Univ. Hosp. Balto, Md. Date signed 6/17/45 M. D.

G29892 G29892

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH

Registered No. 1707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co. Md.
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Solley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Knaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife. Augusta Knaus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th 1869

8. AGE: Years 76 | Months — | Days 26 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name —
13. Birthplace Germ.

MOTHER
14. Maiden Name —
15. Birthplace Germ.

16 (a) Informant Family

(b) Address 3101 Waverly Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Ritchie Highway

18 (a) Funeral director James L. McCauley

(b) Address 130 E. Fort Ave.

19 (a) JUN 18 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

35

20. DATE OF DEATH June 14 1945, at 1 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to him death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Fractures Thoracic vertebra (Broken back)

Due to

Other Conditions Generalized atherosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1:35 A.M. 6-14-45 25-5

(b) Where did injury occur? Pennington Ave. Extended

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Mudd M.D. Medical Examiner.

Date signed 6-14-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G29893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 S. Bond Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Ryncewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1935

8. AGE: Years	Months	Days	If less than one day
10	4	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Konstanty Ryncewicz
13. Birthplace Poland

MOTHER
14. Maiden Name Stanislawa Ruszkowski
15. Birthplace Poland

16 (a) Informant Mrs Stanislawa Ryncewicz
(b) Address 512 S. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 18 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) JUN 18 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945 to June 15 1945 and that I last saw him alive on June 15 1945.

Immediate cause of death Acute Leukemia (Terminal)

Due to Cachexia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunter S. Drake M.D.
Address Univ Hosp Date signed 6-15-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G29894

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Fell St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Janowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-22-9674

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
fem	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10 - 1927

8. AGE: Years	Months	Days	If less than one day
18	3	05	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business Clothing Factory

FATHER
12. Name James Janowski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Helen Krol
15. Birthplace Baltimore

16 (a) Informant Mrs Helen Janowski
(b) Address 921 Fell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (month) 19 (day) 45 (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

JUN 18 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 15 1945, at 12:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 12 19 , to 6 - 15 1945 and that I last saw h[illegible] alive on 6 - 15 19 45.

Immediate cause of death Peritonitis — Duration
Due to Pelvic abscess (etiology unknown)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. K. Kerperson M. D.
Address 3 Franklin Sq Hosp Date signed

G29895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29895 Registered No. 1700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Balto.~~ Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Virginia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES A. WIGGINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race COLORED

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ethel X Wiggins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Harford C. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wesner Higgins

13. Birthplace Harford C. Md.

MOTHER 14. Maiden Name Cubie Banks

15. Birthplace Harford Co. Md.

16 (a) Informant Wilbur F. Higgins

(b) Address 1200 N. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18th 1945 (month) (day) (year)

(c) Cemetery or crematory Pleasant Rest

Location Towson Md.

18 (a) Funeral director Bafford Memorial Chapel

(b) Address 72 Aisquith St

19 (a) (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945, at 10A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of neck; Crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-15-45 at A. M.
(b) Where did injury occur? West Joppa Rd. near Ballona Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury "Hit & Run"

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 15 1945

G29896 ✓ G29896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Pelham ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Pelham ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Howard Evans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Madeline Le Brun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11 1881

8. AGE: Years	Months	Days	If less than one day
64	4	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Supt. A.S.R. Co.
11. Industry or business

FATHER
12. Name David Evans
13. Birthplace Wales

MOTHER
14. Maiden Name Hannah Williams
15. Birthplace Baltimore, Md.

16 (a) Informant Wife
(b) Address 2203 Pelham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18 '45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemt.
Location

18 (a) Funeral director Clarance F Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

VS 19 JUN 18 1945 Huntington W. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945 to June 15 1945 and that I last saw him alive on June 15 1945

Immediate cause of death: Uremia — Duration: 3 days
Due to: Cardio-renal disease — 2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos E Pilson M.D.
Address 3 W. Biddle Date signed 6-17-45
3 W. Biddle St

G29897 X G29897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town 5248 Wasena Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto #25
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOAN LYONS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age 19 4 years

7. Birth date of deceased (mo., day, yr.) Oct 9-45

8. AGE: Years	Months	Days	If less than one day
	8	7	hr. min.

9. Birthplace Virginia
(City, town, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Staff Sgt Ralph Lyons
13. Birthplace Canada

MOTHER
14. Maiden Name Frances Lyons
15. Birthplace Virginia

16 (a) Informant Frances Lyons
(b) Address 5248 Wasena Ave (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19-45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St (25)

JUN 18 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to June 16 1945 and that I last saw h PR alive on June 16 1945.

Immediate cause of death Congestive Heart Failure — Duration

Due to Patent Interventricular Septum

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H. Mosberg Jr. M.D.
Address University Hospital Date signed 6/16/45

X

G29898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G29898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 N. Central Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. Central Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Durival Otis Aquilla.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-1389

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1876

8. AGE: Years 69 | Months 2 | Days - | If less than one day ___ hr. ___ min.

9. Birthplace Hartford County (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Aquilla

13. Birthplace Maryland Fed Co

MOTHER 14. Maiden Name Baltimore, Savoy

15. Birthplace Frederick Co Md

16 (a) Informant Alice R. Manahuring

(b) Address 1252 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County, Md.

18 (a) Funeral director Joseph G. Locke

(b) Address 1304 N. Central Ave

19 (a) (To be signed by registrar) (b) JUN 18 1945 Registrar, Washington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 June 1945, at 9.0 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 11 1945 to June 14 1945 and that I last saw h[illegible] alive on 14 June 1945

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Hypertension, malignant

Due to: Cerebral Renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert C. Bunnell M.D.

Address 121 Eutaw St Date signed 14 June 1945

X

G29899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G29899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 W. Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Mc Gruder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1888

8. AGE: Years	Months	Days	If less than one day
57	3	2	hr. min.

9. Birthplace Richmond - Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Benjamin Mc. Gruder
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Georgianna Slater
15. Birthplace Richmond, Va.

16 (a) Informant Gazell Williams
(b) Address 1408 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. Ar County Md.

18 (a) Funeral director Chas. H. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) JUN 19 1945 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 11:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 6-18-45

X

G29900 ✓ G29900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 877 N Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Foster

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Elsie
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 2-5-1905

8. AGE: Years	Months	Days	If less than one day
40	4	10	hr. min.

9. Birthplace Gloucester, Va. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name John Foster
13. Birthplace Gloucester, Va.

MOTHER
14. Maiden Name Missouri Kemp
15. Birthplace Gloucester Va.

16 (a) Informant Missouri Foster (M)
(b) Address 879 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto. County Md.

18 (a) Funeral director Charles H. Cooper
(b) Address 512 Carrollton Ave.

19 (a) JUN 18 1945 (Date rec'd by Registrar) Huntington Woodlawn, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15- 1945, at 10:40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Spleen
Fractured ribs
Due to Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-9-45 at 7-5 12.15 A M.
(b) Where did injury occur? Broadway & Madison St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Person struck by automobile

23. Signature Howard J. Mencken M.D. Medical Examiner.
Date signed 6-16-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G29901 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens, Ave.
(c) Hospital or institution: Hospital, St. Agnes'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Woodlawn, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5311 Windsor Mill, Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Scott Winfield Standiford
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-12-7843

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Mary A. Standiford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1876

8. AGE: Years	Months	Days	If less than one day
69 years	2	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Supt of Bldg.
11. Industry or business Own Made

FATHER
12. Name W. S. Standiford
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bowen
15. Birthplace Va.

16 (a) Informant Mrs. Mary A. Standiford
(b) Address 5311 Windsor Mill Road

17 (a) Burial (b) Date thereof 6-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3407 W. North Ave

JUN 18 1945 Huntington Williams
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945 to 6/17/1945 and that I last saw him alive on 6/17/1945

Immediate cause of death Heart Failure — Duration: ?

Due to Bronchogenic Carcinoma Left Lung. — Duration: 2 years

Due to — Duration:

Other Conditions Lung Abscess Left — Duration: 5 years

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Ratliff Jr. M.D.
Address St. Agnes Hospital Date signed 6/17/45

VS 150

G29902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G29902 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Lawrence
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Lawrence (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Joseph Greb.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	widowed

6 (b) Name of husband or ~~wife~~ Barbara Greb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24-1879

8. AGE: Years	Months	Days	If less than one day
66 65	3	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Sheet metal worker

11. Industry or business (Retired)

FATHER
12. Name August Greb
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Lindner
15. Birthplace Germany

16 (a) Informant Harry Greb
(b) Address 618 Lawrence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director George Weber & Son
(b) Address 2583 Edmondson Ave.

JUN 18 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 17 1945 and that I last saw him alive on June 16 1945

Immediate cause of death — Duration

Cerebral Hemorrhage — 6/11/45

Due to

Due to Chr. Myocarditis — 4 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Bowen M.D.

Address 1663 W Fort Ave Date signed 6/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29903 ✓ G29903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Oak Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Oak Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAURA V. STREET

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Palmer C. Street
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1882

8. AGE: Years	Months	Days	If less than one day
62	9	13	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles E. Morgan
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Della
15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Cora E. Sweet
(b) Address 3006 Oak Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 18 1945 (Date rec'd by registrar) Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945, at 8:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to June 15 1945. and that I last saw h[illegible] alive on June 14 1945

Immediate cause of death	Duration
Cerebral Vascular Accident	4 mos.
Due to Arteriosclerosis	2 yrs.
Due to Right sided Paralysis	4 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. G. Abbott M. D.
Address 4509 Liberty Heights Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29904 ✓ G29904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Powhatan Ave.
(c) Hospital or institution:
15 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Powhatan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAPT. HANS MARTIN SORENSEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grethe I. Sorensen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1877

8. AGE: Years	Months	Days	If less than one day
67	6	10	hr. min.

9. Birthplace Copenhagen, Denmark
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hans Sorensen
13. Birthplace Denmark

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Grethe I. Sorensen
(b) Address 3507 Powhatan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 18 1945 (Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1945, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945 to June 16 1945.
and that I last saw him alive on June 14 1945.

Immediate cause of death	Duration
Despite Ceremonies	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 1123 St. Paul St. Date signed 6/15/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126 G29905 File No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. Gen Hospital. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 York Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie H. Gardner

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry Skeen Gardner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 6, 1867

8. AGE: Years 78 | Months 2 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Hagan
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Rachel Bulls
15. Birthplace: Unknown

16 (a) Informant: Mr. Walter Hett
(b) Address: 766 Norchester Ave., Norfolk, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

JUN 18 1945

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17-1945, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10-1945 to 6-17-1945 and that I last saw her alive on 6-17-1945

Immediate cause of death: Later Pneumonia — Duration: 3 days

Due to:

Due to:

Other Conditions: Intestinal Obstruction due to Gall Stone.
(Include pregnancy within 3 months of death)

Date of operation: 6-13-45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John Mollison Blythe III M. D.

Address ... Date signed ...

VS 150

Courtesy of Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G29906 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 Maryland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN P. TURNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Louisa Mason Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1862

8. AGE: Years	Months	Days	If less than one day
82	9	26	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name William Ball Turner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Louisa Brotherton
15. Birthplace Balto., Md.

16 (a) Informant Mrs. J. C. Sullivan
(b) Address 2721 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore,
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address JUN 18 1945 Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1945, at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1935 to June 16 1945, and that I last saw h. alive on June 16 1945.

Immediate cause of death: Pneumonia — Duration: 4 days
Due to: Carcinoma of Urinary Bladder. — 24 mos
Due to:
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 2727 N. Charles St. Date signed June 18-45

G29907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G29907
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakeside Pky 34th St
(c) Hospital or institution: Gamebridge Comm dept
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lakeside 3416 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Elizabeth Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Guy Dugles Boston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30th 1906

8. AGE: Years	Months	Days	If less than one day
38	10	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Social Security Board

FATHER
12. Name J. Adam Madigan
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Eva E. K. Hoffman
15. Birthplace Baltimore, Md.

16 (a) Informant Guy Dugles Boston
(b) Address Gamebridge Comm dept

17 (a) Burial (b) Date thereof 6/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director F. D. Mumpert Inc
(b) Address 1300 Eutaw Place

19 (a) JUN 18 1945 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1944 to 6/15 1945; and that I last saw her alive on June 15 1945.

Immediate cause of death Cachexia — Duration
Due to Hepatic Malignancy
Due to Origin - undetermined
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Dec. 10, 1944.
Major findings of operation: Hepatic Malignancy
of autopsy? Origin undetermined

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris Faulcon
Address 11 E. Chase St Date signed 6/18/45
Balto. 2, Md X

VS 150

G29908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29908 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4003 Wilsby Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Wilsby ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Hedrick

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John C. Hedrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16-1856

8. AGE: Years 88 | Months 9 | Days 30 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Jacob Daub

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Mrs Josephine Hedrick

(b) Address 4003 Wilsby Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore Md

18 (a) Funeral director F. O. Wisgant & Son

(b) Address 300 Eastern Ave

19 (a) JUN 18 1945 (Date received by registrar) Huntingtown, Md. (b) Place of burial

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15th 1945 at 1.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-1 1945, to June 15 1945 and that I last saw he alive on June 12 1945

Immediate cause of death Coronary occlusion — Duration

Due to Diabetes mellitus

Due to Arteriosclerosis

Other Conditions Senility

Left Ovarian Cyst.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.

Address 300 Shannon Dr Date signed 6/16/45

VS 150

G29909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G29909

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: MERCY HOSP

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A.

(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town 2436 KEYWORTH AVE

(If outside city or town limits, write RURAL and give town)

(d) Street No. BALTIMORE

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** CHARLES ALTSHULL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife HELEN A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Benj ALTSHULL

13. Birthplace RUSSIA

MOTHER 14. Maiden Name JETTA A

15. Birthplace RUSSIA

16 (a) Informant ALBERT ALTSHULL

(b) Address -SON

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location O'Donnell St

18 (a) Funeral director Jack Benjamin

(b) Address 1439 E. Balto St

19 (a) JUN 18 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 11:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1945 to 6/17 1945, and that I last saw him alive on June 1945.

Immediate cause of death Heart failure

	Duration
Due to Coronary thrombosis	
Due to Aggravated factors	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr E S Purpont to Piersont M.D.

Address Mercy Hosp Date signed 6/18/45

VS 150 For H.C. Sheehan (substitute Med. Exam.) by Howard J. Thomas M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G29910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Victory Rd (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** MORRIS SASS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Rumney (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Nathaniel

13. Birthplace Rumney

MOTHER 14. Maiden Name Gertrude

15. Birthplace Rumney

16 (a) Informant Boy. Sass

(b) Address 572 P Jongeil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-45 (month) (day) (year)

(c) Cemetery or crematory Regular

Location Pt Pl Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St.

19 (a) JUN 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1944 to 6-17 1945 and that I last saw h[illegible] alive on 6-17 1945.

Immediate cause of death	Duration
Arteriosclerosis	
Hypertension	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H Edmund Levin M. D.

Address Levindale Date signed.....

VS 150

X

G29911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓84a

G29911 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Dunvael Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Dunvael Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME AMY FLAX

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 27 1944

8. AGE: Years	Months	Days	If less than one day
1	3/15	21	hr. min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ERWIN FLAX
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name ANN DUNIE
15. Birthplace NORTH CAROLINA

16 (a) Informant FATHER
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-18-45 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO. & CONKLIN STS.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 JUN 18 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-45 19 , at 8:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945, to June 18 1945, and that I last saw her alive on June 18 1945

Immediate cause of death	Duration
Respiratory failure	
Due to TAY-SACHS Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. Sloofman M. D.
Address 6010 Monsdale Ave Date signed 6/18/45

G29912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G29912 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balti. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karl Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna Schwartz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Page Levin Inc
(b) Address 1439 E. Balto. St.

JUN 18 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 17 1945 and that I last saw him alive on June 17 1945

Immediate cause of death	Duration
Cerebral edema	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin Lambert
Address Sinai Hosp. Date signed 6/18/45

VS 150

G29913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G29913 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp 6th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 E Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Eli Grenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Fetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 61 | Months | Days | If less than one day * hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Caley
15. Birthplace Russia

16 (a) Informant Supt Greenberg
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hwy & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Baltimore St (b) Huntington Williams, Mgr

JUN 18 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/1945 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17/1945 to 6/17/1945 and that I last saw him alive on 6/17/1945

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Hypertension - Arteriosclerosis with M. A.	
Due to Generalized arteriosclerosis	
Other Conditions Myocardial insufficiency	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry M. Kelly M.D.
Address 1 W Mt Vernon Pl Date signed 6/18/45

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G29914 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Esplanade Apts.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MOLLIE W. CAHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Abraham Cahn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1862.

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Unknown. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lazarus Weinberg,
13. Birthplace Russia.

MOTHER
14. Maiden Name Bertha Goldstein,
15. Birthplace Russia.

16 (a) Informant Mr. C. Cahn,
(b) Address Esplanade Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ 18/45. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date received) JUN 18 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944 to June 16 1945 and that I last saw h~~er~~ alive on June 15 1945

Immediate cause of death	Duration
Senility — Arterio-Sclerosis —	2-3 yrs
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Emma E. Cahn

Address Esplanade Apts. Date signed 6/16/45 M. D.

Registration Williamsport, Md.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29915 (Baltimore) G29915 (Registered No.)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Chapel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** Anna Marie Rajek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Vaclav Rajek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1843

8. AGE: Years	Months	Days	If less than one day
102	5	10	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

PARENTS

12. Name of father Pavel Balaceh
13. Birthplace of father Bohemia
14. Maiden name of mother Marie Nedvornik
15. Birthplace of mother Bohemia

16 (a) Informant Marie C. Rajek
(b) Address 819 N. Chapel St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Balto Md

18 (a) Funeral director Ingold-Graydon
(b) Address 900 W. Chester St

19 (a) (Signature of Registrar) (b) Huntington Williams, M.D. Registrar

JUN 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 , 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945. to June 16 1945. and that I last saw her alive on June 16 1945.

Immediate cause of death Bronchio Pneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny
Address 2200 E. Madison St Date signed 6/18/45 (M. D.)

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G29916

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katarzyna adamska

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Johan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years About 75 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Janowski
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Agnes Adamski
(b) Address 309 S. Chester St

17 (a) Burial (b) Date thereof 6-20-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director W. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at 3:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 10 1945 to June 16 1945 and that I last saw h[illegible] alive on June 16 1945

Immediate cause of death Carcinoma of Stomach — Duration 7 mos.

Due to

Due to

Other Conditions Cirrhosis - Ascites — 3 yrs.
Appendectomy Myocarditis Dyspnea
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Surdler

Address 1701 E. Fayette St Date signed M. 6 D. 18/45

X

G29917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

Registered No. G29917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Haven St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Haven St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward John Westerveldt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Catherine M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 - 1860

8. AGE: Years 84 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Grocery Mer.

FATHER
12. Name Richard Westerveldt
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Mc Caffery
15. Birthplace Phila Pa

16 (a) Informant Mary C. Sons
(b) Address 112 N. Haven St

17 (a) Burial (b) Date thereof 6-21-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) (b) Huntington Williams Md

JUN 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1945 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/7 1945 to 6/17 1945
and that I last saw h alive on 6/17 1945

Immediate cause of death Heat Prostration

Duration 6 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/4
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Knight A. Snedden

Address 3373 E. Baltimore St Date signed 6/18/45

X

G29918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56D

Registered No. G29918

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3342 Elmley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD MEINHARD HARBERTS

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 213-16-3341

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 16, 1922

8. AGE: Years 23 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Glenn L. Martin Co.

11. Industry or business Tool Crib

FATHER
12. Name Meinhard A. Harberts
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Hilda Ahrendt
15. Birthplace Baltimore, Maryland

16 (a) Informant Meinhard A. Harberts
(b) Address 3342 Elmley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JUN 18 1945 Huntington Williams, M.D.
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to June 15 1945, and that I last saw him alive on June 12 1945.

Immediate cause of death: Bilateral acoustic neuroma & metastatic neurofibromatosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Stirt Hollyes M. D.
Address Date signed

VS 150

G29919

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 1709

G29919

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? –
Hospital, institution, or street address where death occurred:
Baltimore City Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa County:
City or town: Willow Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Alfred H. MUIR, 33,829,127

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): July 31, 1914

8. AGE: Years	Months	Days	If less than one day
30	8	12	...hrs. ...min.

9. Birthplace: Bresher town, Pa. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Mrs Mary (unknown) Muir
15. Birthplace: Edison, Pa.
16. Informant: Service Record
Address: U. S. Army
17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 12 1945 (month) (day) (year)
Cemetery or crematory: J E Helwig Funeral Director
Location: 463 York Rd., Jenkentown, Pa.
18. Funeral director: Howard H. Blight Jr
Address: 4914 Belair Rd, Baltimore, Md.
19. April 12 19 45 W J Lawson Jr
(Date rec'd by registrar) W. J. LAWSON JR 1st Lt MAG Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 // 19 45, at 7:50 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19..., to ... 19...; and that I last saw h... alive on ... 19...
Immediate cause of death: Wound of brain with hemorrhage & pulmonary edema — DURATION
Due to: Skull fracture, compound, severe
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op. ...
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ACCIDENT Date of: APRIL 8, 1945
Where did injury occur? MACE AVE., (City or town) ESSEX, (County) BALTO. COUNTY, MD. (State)
Injured at home, farm, industry, public place (where?) PUBLIC PLACE
Means of injury: LOST CONTROL OF MOTORCYCLE Injured at work? YES

23. SIGNATURE: True Lawson Jr M. D. or other
Address: Hospital Hosp #66 Md Date signed: 8 Apr 45

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a G29920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Violet Crutchfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1883

8. AGE: Years 61 | Months 9 | Days | If less than one day ... hr. ... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Sturgis
13. Birthplace N. C.

MOTHER
14. Maiden Name Sturgis
15. Birthplace N.C.

16 (a) Informant Mabel Crutchfield
(b) Address 607 Jasper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Bolton Hill Ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

JUN 18 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1945 to 6/17 1945, and that I last saw h[illegible] alive on 6/17 1945

Immediate cause of death	Uremia	Duration
Due to	Athero sclerosis	
Due to	Changes of kidneys	
Other Conditions	Carcinoma left breast & ulceration	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. B. Burley M.D.

Address Univ. Hospt. Balto Md. Date signed 6/18/45

X

G29921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Evanko / 157E

G29921

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Univ. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)

(d) Street No. 134 Sanford Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Evanko

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/45

8. AGE: Years	Months	Days	If less than one day
	3	13	hr. min.

9. Birthplace St. Agnes Hosp Balto
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Michael Evanko

13. Birthplace Hazelton Penna.

MOTHER

14. Maiden Name Virginia Cole

15. Birthplace Catonsville Md.

16 (a) Informant Eugene C. Cole

(b) Address 134 Sanford Ave. Caton 2122

17 (a) Burial (b) Date thereof June 20, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Easton, Jones

(b) Address 608 Frederick Ave Caton

19 (a) (b)
(Date received by registrar)

JUN 18 1945

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 19 45 at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ~~6/15~~ 19 D.O.A. 19, and that I last saw h alive on 6/17 19 45

Immediate cause of death Paroxysmal tachycardia — Duration

Due to Congenital heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

Signature A Robert Mark M. D.

Address Univ Hosp Date signed 6/17

X

G29922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29922 Registered No. 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Daniels, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA RUDACILLE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Joseph Kiger Rudacille
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 13, 1862
8. AGE: Years 82 | Months 11 | Days 4 | If less than one day ... hr. ... min.
9. Birthplace: Brownstown Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Levi Marlow
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Ann Tracewell
15. Birthplace: Virginia

16 (a) Informant: Mr. Bernard Rudacille
(b) Address: Daniels, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1945 (month) (day) (year)
(c) Cemetery or crematory: Good Shepherd
Location: Howard Co., Md.
18 (a) Funeral director: Easton Sons
(b) Address: Ellicott City, Md.

JUN 18 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION 40

20. DATE OF DEATH June 17 1945, at 11 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to June 17 1945 and that I last saw her alive on June 16 1945.

Immediate cause of death: Respiratory failure — Duration
Due to:
Due to:
Other Conditions: Fracture of hip
CVD: ARTERIOSCLEROTIC
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: 6-17-45 at 4 P.M.
(c) Where did injury occur? Daniels, Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work? No (Specify type of place)
(e) Means of injury: Lost footing — Slipped on floor
23. Signature: R. S. Normenti M.D.
Address: Univ. Hosp. Date signed 6/17/45

VS 150

-NORMENTI-

Affirmed by Howard L. Andes, M.D.

G29923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G29923 Registered No. 1318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3614 Gibbons Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3614 Gibbons Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FILEMON ZACHARKO

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Wiesniowczek, Austria (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Omufrey Zacharko

13. Birthplace Wiesniowczek, Austria

MOTHER

14. Maiden Name Polagna Belszecka

15. Birthplace Wiesniowczek, Poland

16 (a) Informant Mr. James Zacharko

(b) Address 3614 Gibbons Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son

(b) Address 1808 Eastern Ave

19 (a) (b) (Signature of undertaker)

JUN 18 1945

Huntington Hillsmeyer

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1945 at 10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 19 44 to 6/16 19 45 and that I last saw h in alive on 6/16 19 45.

Immediate cause of death Myocardial degeneration.

Due to Senility

Due to

Other Conditions Chr. Nephritis, Terminal Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 4613 Eastern Ave Date signed 6/18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.

G29924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G29924 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Hosp. for Women of Md. v
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1159 Sargent St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Louise Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Frank J. Baker
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) 11/14/1887

8. AGE: Years	Months	Days	If less than one day
57	7	12	hr. min.

9. Birthplace Balto., Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name FRED SNYDER
13. Birthplace MD

MOTHER
14. Maiden Name MARY SUMMERS
15. Birthplace MD

16 (a) Informant Frank J. Baker
(b) Address 1159 Sargent St.

17 (a) BURIAL (b) Date thereof 6-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director Bernard C. Hahn
(b) Address 121 ½ West St.

JUN 18 1945
(Date received by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1945, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1945 to 6/16 1945; and that I last saw h.e.r alive on 6/16 1945.

Immediate cause of death Peritonitis

Duration 2 days

Due to Cholecystostomy for suppurative Gall Bladder.

Due to Pulmonary Embolism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/14/45

Major findings of operation: Abdominal abscess around drainage tube

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Hetou, M.D.
M. D.
Address Hosp. for Women of Md. Date signed 6/19/45

X

G29925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G29925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5002 Frederick Rd.
(c) Hospital or institution: Kennedy Institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 yrs. 7 mos. 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Frederick Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Adele Cecelia Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20 1862

8. AGE: Years	Months	Days	If less than one day
82	9	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Lady

11. Industry or business

FATHER
12. Name Henry Hammond
13. Birthplace New York

MOTHER
14. Maiden Name Adele Hopkins
15. Birthplace Washington DC

16 (a) Informant Mrs. Juliet H. Price
(b) Address 3423 Guilford Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Balto., Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JUN 18 1945 (Date rec'd by Reg.) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1900 to June 17 1945, and that I last saw h~~e~~r alive on 3-30 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to Feeble health for 44 yrs	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen V. Kennedy M. D.
Address 5002 Frederick Rd. Date signed 6-17-45
City

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G29926 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun

(c) Hospital or institution:

Franklin Square 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 205 South Gilmore (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME William L. Kaufman

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1876

8. AGE: Years 69 Months 3 Days 13 If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Louis Kaufman

13. Birthplace Balto

MOTHER 14. Maiden Name Johana Passing

15. Birthplace Germany

16 (a) Informant Mary R. Beeler

(b) Address 705 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 - 1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem. Location Balto Md

18 (a) Funeral director Roth C & B. M. Walters

(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) (b) (Registrar)

JUN 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 15 1945, at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1945 to 6-15 1945 and that I last saw him alive on 6-15 1945.

Immediate cause of death	Duration
Terminal pneumonia	
Due to	
Due to	
Other Conditions Low grade diabetes	

(Include pregnancy within 3 months of death)

Date of operation 6-15-45

Major findings of operation: Fracture of left hip (Subtrocanteric)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence June 14, 1945 at 6 P. M.

(c) Where did injury occur? 205 S. Gilmore St. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Slipped & fell in bathtub

23. Signature H. K. Kezerian M. D.

Address Franklin Sq. Hosp. Date signed 6-15-45

Approved — Howard D. Steele, M.D.

Dr. Machen 929
6304 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G29927
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6414 Rosement Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6414 Rosemont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ellsworth N. Luburg

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-0903-A

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Hattie M. Luburg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1865

8. AGE: Years 79 78 | Months 11 | Days 22 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Tool Maker

11. Industry or business Glenn L. Martin, Co.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. John F. Handley
(b) Address 6414 Rosemont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road -14-

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 19 45 at 5:14 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 43 to 6/17 19 45 and that I last saw him alive on 6/17 19 45.

Immediate cause of death: Myocardial Degeneration — Duration: 2 Mos +

Due to: Arteriosclerotic Heart Disease — "

Due to:

Other Conditions: Diabetes Mellitus — "

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Machen M.D.
Address 6304 Belair Rd Date signed 6/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

93D

G29928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

G29928

Registered No. 60220

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 19 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6108 Old Harford Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Franklin Richard Corner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ardell Billingsley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1903

8. AGE: Years	Months	Days	If less than one day
41	5	25	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Production technician
11. Industry or business Glenn L. Martin

FATHER
12. Name Harry Corner
13. Birthplace ~~Hamilton~~, Canada

MOTHER
14. Maiden Name Laura Evans
15. Birthplace ~~Hamilton~~, Canada

16 (a) Informant Mrs. Ardell Corner
(b) Address 6108 Old Harford Road
17 (a) Burial (b) Date thereof 6-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 530 ~~N~~ Harford Rd.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH June 15 1945, at 7:50 M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1945, to June 15 1945, and that I last saw h. im alive on June 15 1945.

Immediate cause of death	Duration
Reticulum cell sarcoma of right femur with multiple metastases	13 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April 10, 1945
Major findings of operation: Right inter-pelviabdominal amputation
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F Jones M. D.
Address U.S. Marine Hospital Date signed 6/16/45

vs 1a JUN 18 1945

Baltimore 11, Maryland X

Dr. Schuerich G29929
1337 S. Charles St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G29929

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Orlando Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Orlando Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry B Butterfield

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. 212-09-0286

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1880

8. AGE: Years	Months	Days	If less than one day
64	5	21	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business Standard Oil Co

FATHER
12. Name Rodolph A Butterfield
13. Birthplace Turks Island West Indies

MOTHER
14. Maiden Name Mary E McDonald
15. Birthplace St Johns New Brunswick

16 (a) Informant Mrs Nellie E Butterfield
(b) Address 3116 Orlando Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director L J Ruck
(b) Address 5305 Harford

19 (a) (Date rec'd by registrar) (b) Registrar
JUN 18 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to June 15 1945, and that I last saw h[illegible] alive on June 15 1945.

Immediate cause of death	Duration
Cerebral apoplexy.	
Due to	
Due to	
Other Conditions Arteriosclerosis. Hypertension & Myocarditis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Schuerich M.D.
Address 1337 S Charles St Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 Louise Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Louise Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. Mc GREEVY

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-5281

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Caroline
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 19, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	25	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Thomas McGreevy
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Ryan
15. Birthplace Ireland

16 (a) Informant Mrs Vincent Milan
(b) Address 5111 Plainfield Ave.

17 (a) Burial (b) Date thereof 6-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 14 1945 and that I last saw h[illegible] alive on June 12 1945

Immediate cause of death Coronary Occlusion — Duration 10 minutes

Due to

Due to

Other Conditions Chronic myocarditis — Duration 3 years
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury none

23. Signature X. X. Coyle M.D.

Address 5106 Harford Rd. Date signed 6/15/45

X

G29931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G29931 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4914 Arabia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Mr William A Zang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary A. Zang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/14/00

8. AGE: Years	Months	Days	If less than one day
44	11	2	hr. min.

9. Birthplace Balto. Md (Town, county, and State)
10. Usual Occupation Police Officer
11. Industry or business

FATHER
12. Name John C. Zang
13. Birthplace Balto

MOTHER
14. Maiden Name Mary C. Kirchner
15. Birthplace Balto

16 (a) Informant Mrs. Mary A. Zang
(b) Address 4914 Arabia Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6- -45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director E. J. Lucas
(b) Address 5365 Harford Rd.

19 (a) 6 1945 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16/45, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10/45, to 6/16/45, and that I last saw h[im] alive on 6/16/45.

Immediate cause of death	Duration
Terminal hyperpyrexia	
Due to Trauma to Brain	
Due to Brain Tumor	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/14/45
Major findings of operation: Brain Tumor, infiltrating
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Lazarus M. D.
Address 6/16/45 St. Joseph's

VS 155

G29932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G29932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md. 25
(c) ~~Hospital~~ or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-0
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Penrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald R Lanier

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	–

6 (b) Name of husband or wife –

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1935

8. AGE: Years	Months	Days	If less than one day
10	5	13	..... hr. ..... min.

9. Birthplace Thomasville N. C
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Lester Lanier
13. Birthplace Thomasville N. C

MOTHER
14. Maiden Name Lala Reid
15. Birthplace N. C.

16 (a) Informant Lester Lanier
(b) Address 4317 Lanier Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-45 (month) (day) (year)
(c) Cemetery or crematory Thomasville N. C
Location Thomasville N. C

18 (a) Funeral director Martin J Conroy
(b) Address 1600 Holland St

19 (a) 6-7-45 (Date rec'd by registrar) (b) Signature Williams, M.R. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-16-45 at 2 P. M. 25/6
(b) Where did injury occur? Gravel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Found Drowned.

23. Signature Homer L. Wilson M.D.
Medical Examiner.
Date signed June 18/1945.

G29933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G29933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 355 S. Bentalou
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DIED
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 355 S. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-5437

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-1893

8. AGE: Years	Months	Days	If less than one day
51	11	23	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation SHEET METAL WKR

11. Industry or business BETHLEHEM SHPY.

FATHER
12. Name JAMES BOSLEY
13. Birthplace MD.

MOTHER
14. Maiden Name ELLA MADDERS
15. Birthplace MD

16 (a) Informant MRS. EONA NEWELL
(b) Address 127 S. PAYSON ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Dulaney Nat'l Cem.
Location Frederick Rd, Md.

18 (a) Funeral director Harry H. Witzke
(b) Address 410 Edmondson Ave

JUN 18 1945 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15/45, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCauley M.D.
Medical Examiner.
Date signed 6/16/45

G29934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1130

Registered No. G29934

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1839 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Ashland, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Spencer Dennett
13. Birthplace Va

MOTHER 14. Maiden Name Matilda ?
15. Birthplace Va.

16 (a) Informant Cora Armstead
(b) Address 1839 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradley Ave

JUN 18 1945
(Date rec'd by registrar) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION 5-AAR

20. DATE OF DEATH June 14 1945, at 5A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1945, to June 14 1945
and that I last saw alive on June 14 1945.

Immediate cause of death Acute Myocarditis — Duration 1 Day

Due to Acute Nephritis Uremia — 3 mths. 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Long Berry M.D.
Address 1420 E. Chase Date signed 6-18-45

G29935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G29935
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town White Hall Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Kirkwood ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Lena J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation Retired Farmer

11. Industry or business

12. Name Joseph Kirkwood

13. Birthplace Baltimore

14. Maiden Name Elizabeth Stultz

15. Birthplace Baltimore

(a) Informant Mrs. Lena Fleming

(b) Address 726 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1945 (month) (day) (year)

(c) Cemetery or crematory West Lawn

Location White Hall, Md

18 (a) Funeral director Howard S. Franklin

(b) Address White Hall, Md

JUN 18 1945 (b) Huntington Williams
(Date rec'd by Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1945 to 6-18 1945 and that I last saw HIM alive on June 18 1945

Immediate cause of death Resp. Failure — Duration

Due to Congestive Heart Failure

Due to

Other Conditions Bilateral Pulmonary Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Dorsey

Address University Hospital Date signed 6/18/45 D.

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29936 — BALTIMORE CITY HEALTH DEPARTMENT — G29936 Registered No.

CERTIFICATE OF DEATH 137B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Payson Ave
(c) Hospital or institution: West. Balto Gen Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Chatham Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman L. Spinner

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-0085

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna G. Spinner
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) April 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	1	22	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Sattler & Co., Ind.

FATHER
12. Name Philip Spinner
13. Birthplace Erie, Pa.

MOTHER
14. Maiden Name Emma Schaub
15. Birthplace United States

16 (a) Informant Mrs. Edna G. Spinner
(b) Address 4107 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Suitland, Md.

18 (a) Funeral director E W Pamperan
(b) Address 4510 Liberty Heights Ave.

19 (a) (b)
(Date received) (Registrar) Registrar

JUN 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/45 19 , at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/45 19 , to 6/17/45 19 , and that I last saw h alive on 6/17/45 19 .

Immediate cause of death, Respiratory failure — Duration

Due to Septicemia

Due to Prostatic Abcess

Other Conditions Uremia Meningitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A. Donkar M. D.
Address West. Balto Gen Hospital Date signed 6/17/45

Huntington Williams, M.D.

X

G29937

G29937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Leeds Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Leeds Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Hockley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Hockley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 21 1857

8. AGE: Years: 87 | Months: 7 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Anna Doyle
(b) Address: 3108 Leeds Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 19 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore, Md.

18 (a) Funeral director: Wallace Lamborn
(b) Address: 1923 N. Baltimore St

JUN 18 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jun 17 1945, and that I last saw her alive on Jun 15 1945

Immediate cause of death: Exhaustion — Duration: 1 day

Due to: Arteriosclerosis — Duration: Indefinite

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: M. L. Campbell

Address 164 Hanover St Date signed 6/18/45

Huntington for Williams, M.D.

X

G29938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G29938

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County —
(c) City or town WASHINGTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 5916 SECOND ST., N.W. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME LOUIS SIEGEL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MRS. LOUIS SIEGEL
6 (c) If alive, give age 67(?) years

7. Birth date of deceased (mo., day, yr.) 9/25/78

8. AGE: Years	Months	Days	If less than one day
66	8	23	— hr. — min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name ISREAL SIEGEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name IDA RIFKINS
15. Birthplace RUSSIA

16 (a) Informant PT'S. WIFE
(b) Address 5916 SECOND ST, N.W., WASH, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19/45 (Month) (day) (year)
(c) Cemetery or crematory Beth Shalom Cem. Location Washington D.C.

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 1326 D North West

19 JUN 19 1945 (Date rec'd by registrar) Huntington Williams Registrar, M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18, 1945 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1945 to 6/18 1945 and that I last saw him alive on 6/12 1945.

Immediate cause of death PNEUMONIA
due to PERITONITIS

Due to POST-OPERATIVE CARCINOMA OF SIGMOID COLON

Due to —

Other Conditions CARDIAC FAILURE

(Include pregnancy within 3 months of death)

Date of operation 6/6/45

Major findings of operation: CARCINOMA OF SIGMOID COLON

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Siegler III
Address Union Memorial Hospital Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1102

G29939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Stranger

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Audrey Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 - 1921

8. AGE: Years 24 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Kent
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Leonia Phillips
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Leonia P. Kent
(b) Address 638 N. Carrollton Ave

17 (a) Burial (b) Date thereof 6-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

JUN 19 1945 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-44 19 to 6-14 1945 and that I last saw her alive on 6-14 19 45

Immediate cause of death Emphysema — Duration

Due to Pneumonia & Flu

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-1-44, 5-8-45, 5-22-45

Major findings of operation: 10-24-44 Emphysema

of autopsy: Emphysema

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Gleason M. D.
Address Univ. Hosp. Date signed 6-15-45

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

C23940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. C23940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2223 St Paul St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2223 St Paul St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary M. L. O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 Months — Days — If less than one day hr. min. 79

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Gourley

13. Birthplace Ireland

MOTHER 14. Maiden Name Jane H Mahoney

15. Birthplace Md

16 (a) Informant Mr John O'Connor

(b) Address 2223 St. Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem

Location

18 (a) Funeral director Mary M. Wadsfield

(b) Address 521 E. 22nd St

JUN 19 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to June 16 1945 and that I last saw h[illegible] alive on June 16 1945

Immediate cause of death Acute Myocarditis — Duration 1 day

Due to Hypertension — Duration 10 yrs

Due to

Other Conditions Advanced arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Francis L. Bagli M.D.

Address 6077 Hanford Rd Date signed 6/16/45

G29941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G29941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Belvieu Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Monroe St., N. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Arthur Crown

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Clara R. Crown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) -

8. AGE: Years	Months	Days	If less than one day
about 71			hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles R. Crown
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Elizabeth Robinson
15. Birthplace Va.

16 (a) Informant Mrs. May Catherine Hedian
(b) Address 4100 Belvieu Ave. 15

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 19 1945 (Date received by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1945, at 11:50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Pass death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute myocardial degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D. Medical Examiner.
Date signed 6-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 93D

Registered No. G629962

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WBHH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 88 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Joppa Rd. (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Aro

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of ~~husband or~~ wife Edna R. Aro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1874

8. AGE:

Years	Months	Days	If less than one day
71	0	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Wood Worker

FATHER
12. Name William Aro
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Sterling Dorsey
(b) Address 1720 Joppa Rd Towson

17 (a) Burial (b) Date thereof 6/21/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
Huntington Williams, Mgr

19 (a) JUN 19 1945 Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17- 1945 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1945 to 6-17-1945 and that I last saw him alive on 6-17-1945

Immediate cause of death: Respiratory & Cardiac Failure

Duration

Due to Kidney Infection bilateral

Due to Prostatic enlargment

Other Conditions Hypertensive Cardio Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert D. Adams, M.D.
Address West Baltimore Date signed 6/17/45

137a Gen Hosp.

G29943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

✓ G29943 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Hollen Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Benjamin Shaw

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mrs. Geo. B. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Wholesale Flour Business

FATHER
12. Name John W. Shaw
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sidney Lamar
15. Birthplace Baltimore

16 (a) Informant Lucretia O. Shaw
(b) Address 602 Hollen Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) Date received JUN 19 1945 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 7:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 17 1945, and that I last saw h.. alive on June 17 1945.

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Intestinal Obstruction	
Due to Duodenal Ulcer and Pernicious Anemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6-6-45
Major findings of operation: Intestinal Obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchiade Spraggins
Address U. MH. Date signed 6-17-45 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130 ✓

Registered No. G29944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Cecil Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hamilton L Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1860

8. AGE: Years 84 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Letter Carrier Retired

11. Industry or business U.S. Govt.

FATHER 12. Name Zachariah Mitchell

13. Birthplace Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace Md

16 (a) Informant Murray H Mitchell

(b) Address 405 E 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)

(c) Cemetery or crematory Loraine

Location Woodlawn Md

18 (a) Funeral director Wilson Colvin

(b) Address 2107 E Pratt St

JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 7 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from JUN 7 1945 to JUN 17 1945
and that I last saw h[illegible] alive on JUN 7 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 hrs

Due to: Parkinsons

Due to: Disease — 8 yrs

Other Conditions: arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: X X

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence none at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none While at work? none
(Specify type of place)
(e) Means of injury none

23. Signature Otto Bucher M.D.

Address 928 E. North Ave Date signed JUN 18 1945

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G29945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G29945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Augusta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Augusta St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Webb

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1873

8. AGE: Years 71 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Lucinda Montgomery
15. Birthplace Unknown

16 (a) Informant James L Webb
(b) Address 1101 Augusta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilhom Co Inc
(b) Address 1214 E Pratt St

19 (a) JUN 19 1945 (Registered by (Name)) (b) Huntington Wilt Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/N 19[illegible] to 6/15 1945 and that I last saw h[illegible] alive on 19

Immediate cause of death	Duration
Cerebrovascular Cardio-Vascular Renal Disease	7
Due to	
Due to	
Other Conditions Left Hemiplegia Hypertension	1 / 2

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blumenthal M.D.
Address 206 E Preston Date signed 6/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G29946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6512 Glenoak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6512 Glenoak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Foster

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1870

8. AGE: Years 74 | Months 10 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Laborer

11. Industry or business Balto. City

FATHER
12. Name John M. Foster
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John M. Foster
(b) Address 6512 Glenoak Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

JUN 19 1945 (b) Huntington Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1945, to June 16 1945, and that I last saw him alive on June 16 1945.

Immediate cause of death: Chr. myocarditis — Duration: one yr.

Due to: Arteriosclerotic cardio vascular disease — Duration: 5 yrs.

Due to: — Duration:

Other Conditions: — Duration:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ... Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. A. Russi M.D. M. D.
Address 6217 Harford Rd Date signed 6/18/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1312 Registered No. G29947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824-KENTUCKY-AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Kentucky Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) **FULL NAME** ELMER-HOWARD-KLINE

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-6689

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ETHEL-KLINE

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH-17-1893

8. AGE: Years 52 | Months 3 2 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace CARROLLTON-MD
(Town, county, and state)

10. Usual Occupation ENGINER

11. Industry or business KUSTERS-BAKERY

FATHER
12. Name JOHN-KLINE
13. Birthplace MD

MOTHER
14. Maiden Name BETTIE-KNOLS
15. Birthplace ?

16 (a) Informant MRS-ETHEL-KLINE
(b) Address 2824-KENTOCKY-AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 19-1945 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location BALTO

18 (a) Funeral director JOS-J-HERR+SON
(b) Address 3001 KENTOCKY-AVE

19 (a) JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1945, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1943, to June 16 1945, and that I last saw h[illegible] alive on June 15, 1945.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to Hypertensive Cardio-vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Samuel Hoch M. D.
Address 133 E. Madison Ave Date signed 6-18-45

G29948 Leba - NovoGrodsky ✓ G29948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Mean Spring & Belvedere Aves

(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. Levindale (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Leba Novogrudsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Hyman —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years 93 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Leib —

13. Birthplace Russia

MOTHER 14. Maiden Name Riva —

15. Birthplace Russia

16 (a) Informant Mrs. Rebecca Levin

(b) Address 915 W. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-45 (month) (day) (year)

(c) Cemetery or crematory Woodmen Circle

Location Hebrew Mt. Carmel

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1439 E. Balto. St

19 (a) JUN 19 1945 (Registrar's number) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1943, to 6-18 1945, and that I last saw h er alive on 6-18 1945.

Immediate cause of death Chr. card. vascular disease — Duration

Asteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Edmund Levin M.D.

Address Levindale Date signed 6/19/45

G29949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G29949 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1215 Light St

(c) Hospital or institution: South Baltimore Gen. Hosp. 3 hrs

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs 30 Min

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 221 Churchill St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT LEE WEST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1944

8. AGE: Years	Months	Days	If less than one day
1	-	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Thomas West

13. Birthplace N.C.

MOTHER

14. Maiden Name Bessie Hoover

15. Birthplace S.C.

16 (a) Informant (Mother) Bessie West.

(b) Address 221 Churchill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Annapolis Blvd A&S

18 (a) Funeral director John F Kenny Inc

(b) Address 711 Light St

19 (a) JUN 19 1945 (Date received by registrar) Registrar

Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 11.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7:30 PM 6/16 1945 to 11.05 6/16 1945 and that I last saw him alive on 6/16 1945

Immediate cause of death Acute Gastroenteritis — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John Madison Bloom III M.D.

Address South Bos St Hosp Signed 6/16/45

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Colored

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83

Registered No. G29950

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 N. Central Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara Marshall White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1891

8. AGE: Years 54 | Months 3 | Days 1 | If less than one day: hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name John Marshall

13. Birthplace Va.

14. Maiden Name Susie Clark

15. Birthplace Va.

16 (a) Informant Elizabeth Taylor

(b) Address 221 Cherry Hill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location B. C. County Md

18 (a) Funeral director Mrs. Robt. Ellis & Sons

(b) Address 1129 N. Carrollton St.

19 (a) JUN 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 16 1945, and that I last saw h[illegible] alive on June 14 1945.

Immediate cause of death: Apoplexy — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions Heart + Kidneys

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 7034 Lafayette Date signed 6/18/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6299452 93

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1390

Registered No. 689954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Carolina St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nannie Singleton.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) P 1871

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ben Perkins
13. Birthplace Va

MOTHER
14. Maiden Name Charlotte Cook
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof June 19/45 (month) (day) (year)
(c) Cemetery or crematory
Location Branchville Va

18 (a) Funeral director Mrs. Roberts-Ellis Funeral Dir.
(b) Address 1129 N. Carolina St.

19 JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 17 1945; and that I last saw her alive on June 17 1945

Immediate cause of death Peritonitis — Duration 10 days

Due to ?

Due to

Other Conditions Diabetes Mellitus, Hypertensive Cardiovascular Disease, Chronic Cystitis (Including pregnancy, childbirth, and abortion)

Date of operation 6-11-45

Major findings of operation: Peritonitis & pelvic abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John McGee M.D.

Address The Johns Hopkins Hosp. Date signed 6-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G29952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 S. Carrison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 3
(e) Length of stay in Baltimore (yrs., mos., or days) Forgeen

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 S. Carrison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence L. Kneller Sr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Augusta L. Kneller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1885

8. AGE: Years 60 Months 2 Days 4 If less than one day hr. min.

9. Birthplace Manchester Lancaster Co Pa (Town, county, and state)
10. Usual Occupation Wood Worker
11. Industry or business Wm Gehr Co

FATHER
12. Name Wm Kneller
13. Birthplace Md

MOTHER
14. Maiden Name Lizzie Albaugh
15. Birthplace Md

16 (a) Informant Augusta L. Kneller
(b) Address 405 S. Carrison St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. B. Hospicot Son
(b) Address 1300 Eutaw Place

19 JUN 19 1945 (Date received by registrar) (b) Hunter for Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16/45 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to June 16 1945. Last saw him alive on June 15 1945.

	Duration
Immediate cause of death Acute cardiac failure	1 week
Due Chronic nephritis	1 yr
Due Carcinoma of prostate	2 yrs.
Other Conditions Edema of limbs & abdomen (Include pregnancy within 3 months of death)	
Date of operation 2 yrs ago	
Major findings of operation Carcinoma of prostate	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Peirce M. D.
Address 202 W North Ave Date signed 6-18-45

G29953 ✓ G29953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) ~~Length of stay in hospital or inst. (yrs., mos., or days)~~ Life
(e) Length of stay in Baltimore (yrs., mos., or days) 77

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2423 W Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Feldmann

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: Daniel Feldmann
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868
8. AGE: Years 77 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Wm Menke
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Missing Topp
15. Birthplace Germany

16 (a) Informant Mrs Leonie Feldmann
(b) Address 2423 W. Lanvale St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md
18 (a) Funeral director F. P. Wappler & Son
(b) Address 1300 Eutaw Place
19 (a) JUN 19 1945 (b) Transferred to Williams, Md.
Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1945, at 2 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 19 , to 6-18 1945
and that I last saw her alive on 6-18 1945.

	Duration
Immediate cause of death: Terminal Bronchopneumonia	? 1 day
Due to: Diabetic, Arteriosclerotic Gangrene, Left Foot	10 days
Due to: Diabetes Mellitus	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation 6-13-45
Major findings of operation: Gangrenous Left 4th Toe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert D Doty M. D.
Address Church Home & Hosp. Date signed 6-18-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

✓ G29954 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 8 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 9
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Bonner Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter K. Hobbs

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma M. Hobbs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	5	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Mgr.
11. Industry or business Arbutus Mem. Com.

FATHER
12. Name George F. Hobbs
13. Birthplace Howard Co. Md

MOTHER
14. Maiden Name Cornelia Kesler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma M. Hobbs
(b) Address 3812 Bonner Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 19 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945, to 6/17 1945, and that I last saw h[illegible] alive on 6/17 1945.

Immediate cause of death	Duration
Cardiac failure	
Interstinal obstruction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hospital Date signed 6/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29955 ✓X G29955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Gith

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Frederick W. Gith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 1876

8. AGE: Years: 68 | Months: 7 | Days: | If less than one day: hr. min.

9. Birthplace: Pennsylvania (Littlestown)
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Eli H. Snyder
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Emma Jane Spangler
15. Birthplace: Pennsylvania

16 (a) Informant: Mr. Chester Snyder
(b) Address: 20 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1945 to 6/17 1945 and that I last saw her alive on 6/17 1945.

Immediate cause of death: Cardiac FAILURE — Duration:

Due to:

Due to:

Other Conditions: Aspiration, bilateral pleural effusion
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: G. H. Herold, M. D.
Address: Md. Gen. Hosp. Date signed 6/17/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29956 ✓ G29956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: Maryland General Hospital 164
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24hrs
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Mrs. Louise W. Joy

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: James S. Joy

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1878

8. AGE: Years 67 | Months 4 | Days 17 | If less than one day _____ hr. _____ min.

9. Birthplace Port Conway, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business –

FATHER
12. Name William C. Askins
13. Birthplace Port Conway, Va.

MOTHER
14. Maiden Name Elizabeth Burrows
15. Birthplace Port Royal, Va.

16 (a) Informant Mr. James S. Joy
(b) Address 801 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 19 1945 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1945, at — M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1945, to 6/18 1945, and that I last saw her alive on 6/18 1945.

Immediate cause of death Pneumonia — Duration _____

Due to _____

Due to _____

Other Conditions Uremia — Duration over

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
(e) Means of injury _____

23. Signature Charles L. Tilden, M.D.
M. D.

Address Md. Gen'l. Hospt. Date signed 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29957 ✓ G29957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1817 Braddish Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1817 Braddish Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA ZELMER WILMOT

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife George Howard Wilmot

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	28	hr. min.

9. Birthplace Dickeyville, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Calvin Hershey
13. Birthplace Dickeyville, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Agnes W. Berger

(b) Address 1817 Braddish Ave.

17 (a) Burial (b) Date thereof 6/20/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 JUN 19 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16th 1945, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to June 16th 1945, and that I last saw h[illegible] alive on June 16th 1945.

Immediate cause of death

(a) Acute Myocardial Insufficiency

(b) Pulmonary Edema

Due to

Due to

Other Conditions Carcinoma of Bladder
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Bladder

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed June 18, 1945

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 93D

G29958 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson - 4, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Washington Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Frances V. Eareckson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-1896

8. AGE: Years 48 | Months 7 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name William T. Eareckson
13. Birthplace Md.

MOTHER
14. Maiden Name Micha Patterson
15. Birthplace D. C.

16 (a) Informant Mrs. Sewell Hubbard
(b) Address 5304 Maple Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 19 1945 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1945, at 6 40/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1945 to 6-17 1945, and that I last saw her alive on 6-17 1945

Immediate cause of death: Acute Pulmonary Edema & Pneumonia — Duration: 2-3 hrs.
Due to: Removal Pleural Effusion (Thoracentesis)
Due to: Myocardial Degeneration & Subacute Coronary Occlusion
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations: 1200 cc fluid in L chest
of autopsy: Pleural Effusion; Coron. Sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Church Home & Hosp. Date signed 6-17-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G29959

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Kimble Road City (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Edward Wilhelm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1944

8. AGE: Years	Months	Days	If less than one day
	6	0	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George Arvel Wilhelm
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Edith Hill
15. Birthplace Delaware

16 (a) Informant Mr. Geo. A. Wilhelm
(b) Address 3710 Kimble Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md.

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) JUN 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 18 1945, and that I last saw him alive on June 18 1945.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Cerebro-Vascular Accident

Due to Congenital Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred C Hutchinson M. D.
Address 208 E. 34th St Date signed 6-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29960 — BALTIMORE CITY HEALTH DEPARTMENT — G29960

CERTIFICATE OF DEATH 92 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2135 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 Penna Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Edwards

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) ~~Single, Married~~, widowed, or divorced Widow

6 (b) Name of husband or wife Chas W Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25-1848

8. AGE: Years 96 | Months 5 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace York Penna
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Chas Welsh
13. Birthplace York Penna

MOTHER
14. Maiden Name Mary Welsh
15. Birthplace York Penna

16 (a) Informant Wilbur E Edwards
(b) Address 2135 Penna Ave

17 (a) Burial (b) Date thereof June 20-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York Penna

18 (a) Funeral director Bottom & Forr
(b) Address 2224 N Charles St.

19 (a) (b) Huntington Williamsport, Md.
(Date received by registrar) Registrar

VS JUN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June / 1940, to June 16 1945, and that I last saw her alive on June 16 1945.

Immediate cause of death	Duration
(a) Coronary Thrombosis	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Wilbur Frey M. D.
Address 1928 Penna Ave Date signed 6/18/45

G 29961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 29961
Registered No.

FREE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city limits, write RURAL; if in town, give town)
(d) Street No. 731 Hebron Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name not known
13. Birthplace "

MOTHER
14. Maiden Name not known
15. Birthplace "

16 (a) Informant Mrs Amelia Berry
(b) Address 843 Orchard Pl

17 (a) Burial (b) Date thereof 6-20-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances F. Stewart
(b) Address 578 W. Biddle St

19 (a) Received by Local Registrar JUN 20 1948 (b) Huntington Williamsburg, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 48, at 11 A. M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 20, 1948.

G29962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G29962 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Fernhale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEASCEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Fernhale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Rayne Virginia Blundell Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francis E Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/24/1862

8. AGE: Years 83 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Denis E Blundell

13. Birthplace Ireland

MOTHER 14. Maiden Name Rose Breen

15. Birthplace Baltimore

16 (a) Informant Thos R. Rose

(b) Address 3018 Fernhale Ave

17 (a) Burial (b) Date thereof 6/20/45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount Ave

18 (a) Funeral director J. J. Leigh Sons

(b) Address Lexington & Williams Sts

19 (a) (b) Registrar

(Date rec'd by registrar) JUN 19 1945

VS-190

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1945 at 9.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1932 to 6/16/45 and that I last saw h alive on 6/16/45

Immediate cause of death Cerebral Hemorrhage — Duration 10 days

Due to Cardio-Vascular renal disease — 25 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harper M.D.

Address 5201 Kenyon Oak Date signed 6/18/45

The G29963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1830

Registered No. G29963

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 750 Dolphin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 750 Dolphin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J Oliver
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis B Oliver
6 (c) If alive, give age 15 years

7. Birth date of deceased (mo., day, yr.) 1-28-1863

8. AGE: Years 91 92 | Months 6 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name George R. Russell
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Annie
15. Birthplace Balto. Md

16 (a) Informant Charles S. Oliver
(b) Address 750 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Balto Md

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 JUN 19 1945 (Date) (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 19 1945.
and that I last saw h[illegible] alive on June 19 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 4 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. H. Casey M. D.
Address Date signed 6-19-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29964 474883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

Registered No. G29964

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander R. Edmond —

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Arizona
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 3-4-76

8. AGE: Years	Months	Days	If less than one day
69	3	13	..... hr. ..... min.

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Alexander Redmond
13. Birthplace md.

MOTHER
14. Maiden Name Martha Johnson
15. Birthplace W. Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Baltimore Co. Md.
18 (a) Funeral director Mrs Ida Bailey
(b) Address 421 Jefferson St
19 (a) (b) Washington Williamsport Md.

JUN 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 11.59 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to June 17 1945 and that I last saw deceased alive on June 17 1945

Immediate cause of death Carcinoma of the lower bowel of obstruction — Duration

Due to Carcinoma of Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-4-45

Major findings of operation: Carcinoma mucous cell adenocarcinoma

of autopsy: mucous cell adeno CA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Bunch
Address J. H. H. Date signed 6-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29965 G29965

BALTIMORE CITY HEALTH DEPARTMENT

TH. 94218 CERTIFICATE OF DEATH 823 Registered No. G29965

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Dietz

3 (b) If veteran, name war # 1 W.W.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 18, 1888

8. AGE: Years	Months	Days	If less than one day
57	2	19	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name Hyples Dietz (D
13. Birthplace ? GERMANY

MOTHER
14. Maiden Name Auguste Stack (D
15. Birthplace ? GERMANY

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 20/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geisler 1N C.
(b) Address 4015 WOLFE ST.

19 (a) JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 3;00 P.M

20. DATE OF DEATH June 17th, 1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 19 45 to June 17 19 45, and that I last saw h im alive on June 16 19 45

Immediate cause of death Cerebral thrombosis — Duration 1 week

Due to

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H M Bullock
Address Balt City Hosp Date signed 6-17-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 623966

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SINIA HOSP.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S. DUNCAN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Dela Cruz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 16 1945

8. AGE: Years — | Months — | Days 3 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name HICANON DELA CRUZ
13. Birthplace PHIL. ISLANDS

MOTHER
14. Maiden Name MARY WORLEY
15. Birthplace BALTO.

16 (a) Informant MARY WORLEY (MOTHER)
(b) Address 415 S. DUNCAN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 18/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) Date received by registrar 6/19/1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to June 18 1945 and that I last saw h. alive on June 18 1945.

Immediate cause of death: Cardio Respiratory Failure
Due to – Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Bass, M.D.
Address Sinai Hosp. Date signed 6/18/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G29967

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 WEST 30TH STREET.
(c) Hospital or institution: NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTO.
(c) City or town CITY BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 WEST 30TH STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** PAULINE LEDLICH

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: CHARLES LEDLICH

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT. 24 1858

8. AGE: Years 86 | Months 8 | Days 25 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: BERNARD LEDLICH (SON)
(b) Address: 329 W. 30th. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 22/45 (month) (day) (year)
(c) Cemetery or crematory: NEW CATHEDRAL
Location: OLD FREDERICK RD.

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 503 S. WOLFE ST.

19 (a) JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18 1945 19 , at 5. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 12 1945 to JUNE 18 1945 and that I last saw her alive on JUNE 18 1945.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS MAY 12	1945.
Due to ARTERIOR SCLEROSIS	1945.
Due to CHRONIC ARTHRITIS DEFORMANS	1936.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE.
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Chas. F. Blanchee M.D.
Address 3015 ST PAUL STREET Date signed JUNE 18 1945

G29968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G29968 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Bens

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, (widowed) or divorced: WIDOW
6 (b) Name of husband or wife: MARTIN BENS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 17 1896

8. AGE: Years 48 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ARNOLD BENS
13. Birthplace GERMANY

MOTHER
14. Maiden Name KATHERINE G. POLCHER
15. Birthplace GERMANY

16 (a) Informant MATHIAS BEUTGEN (BROTHER)
(b) Address 2725 ASHLAND AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 21/45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK NATIONAL
Location FREDERICK AVE.

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 403 S. WOLFE ST.

19 (a) JUN 19 1945 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 4 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1945 to 6/17 1945.
and that I last saw her alive on 6/17 1945

Immediate cause of death: Hypostatic Pneumonia — Duration

Due to: Mesenteric tuberculosis probably — 2 mo.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None or above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland Gen'l Hospital Date signed 6/18/45

G29969 L. Britt

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √482

G29969 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 N. Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)
(d) Street No. 917 N. Chapel St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Parlis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stanley J. Parlis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1886

8. AGE: Years	Months	Days	If less than one day
58	9	19	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Frank Vakroj
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Lebeda
15. Birthplace Bohemia

16 (a) Informant Stanley Parlis
(b) Address 917 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brocklon
(b) Address 700 N. Alberta St

19 (a) JUN 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945 to June 16 1945 and that I last saw her alive on June 16 1945

Immediate cause of death Cancer of the uterus — Duration 2 yrs.

Due to

Due to

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lemuel Britt M. D.
Address 826 N. Washington St Date signed June 15 1945

X

G29970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G29970 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 E. Hamburg St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. Hamburg
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret S. Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John W. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 - 1861

8. AGE: Years	Months	Days	If less than one day
84	3	0	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Conrad Saffran
13. Birthplace

MOTHER
14. Maiden Name Margaret Reis
15. Birthplace

16 (a) Informant Katherine Van Sitta
(b) Address 29 E. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Pikesville Highway

18 (a) Funeral director Elizabeth Hart Inc.
(b) Address 115 E. West St.

19 JUN 19 1945 (b) Huntington Williams, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Jan 17 1945.
and that I last saw h alive on Jan 16 1945

Immediate cause of death Exhaustion
Cerebral Hemorrhage — Duration 7 days
Due to Mitral Stenosis
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R E L Campbell M. D.
Address 1644 Hanover Date signed Jan 18 1945

VS 150

1644 E. Hanover St.
G29971 Campbell

G29971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1928

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 135 E Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H. Hagner.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1873

8. AGE: Years	Months	Days	If less than one day
71 72	6	14	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm. Hagner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ester Ruber
15. Birthplace Balto., Md.

16 (a) Informant Mary E. Hagner
(b) Address 135 E. Fort Ave.

17 (a) Burial (b) Date thereof 6-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Baltimore Md.

18 (a) Funeral director Leonard L. Covington
(b) Address 21 W. 25th St.

19 JUN 19 1945
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945, to June 18 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Edema of Lungs	5 days
Due to Arterio Sclerosis	Indefinite
Due to Mitral Regurgitation	Indefinite
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Hanover (Date signed) 6/19/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G29972 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1351 Sargeant St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1351 Sargeant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** James B. Ogden

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or ~~wife~~ Julia B. Ogden
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1862

8. AGE: Years 82 | Months 6 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Watchman (Retired)

11. Industry or business

FATHER
12. Name UnKnown Ogden
13. Birthplace UnKnown

MOTHER
14. Maiden Name UnKnown
15. Birthplace UnKnown

16 (a) Informant Julia B. Ogden (wife)
(b) Address 1351 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 160 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17- 1945 at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1945, to June 17, 1945 and that I last saw alive on June 17, 1945.

Immediate cause of death Acute Heart Failure

Due to Myocarditis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Flam M.D.
Address 516 Walbrook Date signed 6/18/45

G29973

HEP - 94202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G29973 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schepf.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Mayers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 65 ?

8. AGE: Years 65? Months ? Days ? If less than one day hr. min.

9. Birthplace ? Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Schepf Sr
13. Birthplace ? Balto

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Gellrich Funeral Home
(b) Address 2015 E. Oliver St.

19 JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

SUBJECT TO APPROVAL OF MEDICAL EXAMINER

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 17, 1945, at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945, to June 17 1945, and that I last saw him alive on June 17, 1945

Immediate cause of death: Pneumonia — Duration: 1 wk.
Uremia — ?
Due to: Prostatic Hypertrophy — ?
Due to:
Other Conditions: Fractured femur — 1 week?
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Pneumonia, Uremia, Hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence unknown at M
(c) Where did injury occur? home Balto md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no.
(Specify type of place)
(e) Means of injury fell in home

23. Signature R. M. Cunningham M. D.
Address B. C. Hospitals Date signed 6-18-45

For Edwin H. Nabb By Howard J. Malone M.D.

G29974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G29974 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: South Balto Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6015 Holabird Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Caroline Hertzberg

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-98

8. AGE: Years	Months	Days	If less than one day
47	2	6	hr. min.

9. Birthplace Pa.

(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Robt. Bennet

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Elizabeth Bennet

15. Birthplace Pennsylvania

16 (a) Informant Mrs Priscilla Shipko

(b) Address 6015 Holabird ave

17 (a) Burial (b) Date thereof June 21

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Matthews

Location City

18 (a) Funeral director Wilhelm Funeral Home

(b) Address 2445 Orleans St

19 (a) JUN 19 1945 (b) Huntington Williams, Mgr.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 1945 at 9 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 1945 to 6-18- 1945 and that I last saw h alive on 6-18 1945

Immediate cause of death Cerebral Hemorrhage — Duration 4 hrs.

Due to Hypertension C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H Ehrlich M. D.

Address 1213 Light St. Date signed 6-18-45

VS 150

X

G29975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/21a

G29975 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs 5
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Oliver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1866

8. AGE: Years 79 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Royal Oak, Md (Town, county, and state)

10. Usual Occupation Cookman

11. Industry or business

FATHER 12. Name Henry Oliver
13. Birthplace Md

MOTHER 14. Maiden Name Mary Betty
15. Birthplace Md

16 (a) Informant Lucy Diggetts
(b) Address 817 N Carline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Caroline St.

19 (a) (Date received by registrar) JUN 19 1945 (b) Signature of registrar Hunting for Wilson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to June 15 1945, and that I last saw h[illegible] alive on June 15 1945.

Immediate cause of death Chronic Nephritis (uremia)

Due to

Due to

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L Young M. D.
Address 1426 E Lanvale St Date signed 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29976

JO #92443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G29976

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 750 W. Franklin St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse James Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 246-09-1335

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1902

8. AGE: Years	Months	Days	If less than one day
42	9	2	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Fairfield Shipyard

FATHER

12. Name William Jones

13. Birthplace North Carolina

MOTHER

14. Maiden Name Sara Wright

15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Removal (b) Date thereof 6/20/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Welden

Location North Carolina

18 (a) Funeral director Isaiah L Brown

(b) Address 1080 W Montgomery St

19 (a) JUN 19 1945 (b) Hunter Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7, 1945 to June 17, 1945, and that I last saw h im alive on June 17, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	
Due to	
Due to	
Other Conditions Tbc of liver	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harold Hilton, M.D.

Address Balto City Hosp Date signed 6/18/45

X

G29977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1925 OMW

Registered No. G29977

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MADISON AVE + CLOVERDALE RD

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 4YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO (If outside city or town limits, write RURAL and give town)

(d) Street No. TEMPLE GARDEN APTS (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rachel (RACHEL) COHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife WOLF COHN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business Corporate Executive

FATHER

12. Name NOT KNOWN

13. Birthplace RUSSIA

MOTHER

14. Maiden Name NOT KNOWN

15. Birthplace RUSSIA

16 (a) Informant FANNIE COHN

(b) Address TEMPLE GARDEN APTS

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)

(c) Cemetery or crematory WASH BLVD

Location WASH BLVD

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St Huntington Hotel Annex, MD

19 (a) (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-45 19 , at 6 59 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1927 19 , to 18 June 1945, and that I last saw her alive on 18 June 19 45.

Immediate cause of death Arterio-sclerotic heart disease — Duration

Due to Arterio-Sclerosis

Due to

Other Conditions Arterio sclerotic gangrene both feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert S. Truitt MD

Address 712 Park Ave Date signed 6/19/45 M. D.

VS 150

PERSONS RESPONSIBLE FOR SENDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

✓ G29978 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Genl. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Tinsley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Zelig ~~Hamberger~~ Hershberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years	Months	Days	If less than one day
17			hr. min.

9. Birthplace New York City (town, county and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER 12. Name Harry
13. Birthplace Russia

MOTHER 14. Maiden Name Celig
15. Birthplace U. S. A

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Bonnel St

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St.

19 (a) JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-18-45 at 15|5 6 P. M.
(b) Where did injury occur? Carlins Pool - Balto. Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Drowning

23. Signature Howard J. Mullers M.D. Medical Examiner.
Date signed 6-19-45

VS 151

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G29979 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Pinewood Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rose Marie Papa.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/19/45

8. AGE: Years	Months	Days	If less than one day
10	—	—	..... hr. ..... min.

9. Birthplace Baltimore.
(Town, county, and state)
10. Usual Occupation Student.
11. Industry or business

FATHER
12. Name Anthony Papa
13. Birthplace Italy

MOTHER
14. Maiden Name Grace Veneziano
15. Birthplace Md.

16 (a) Informant Mr. Anthony Papa
(b) Address 2928 Pinewood Ave

17 (a) Holy Rd. (Burial, cremation, or removal) (b) Date thereof 6-22-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) JUN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19/45 19 ..... at 3 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1945 to 6/19 1945 and that I last saw h er alive on 6/19 1945

Immediate cause of death ..... Duration
Uremia
Due to Renal Failure
Due to Nephritis
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature [signature]
Address St. Joseph Hosp. Date signed 6/19/45 M. D.

VS 150

Dr. S.A.Alessi
6200 Bk. Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G29980

G29930

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3103 Orlando Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Orlando Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Margaret Hoxter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Ernest L. Hoxter
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1899

8. AGE: Years	Months	Days	If less than one day
45	7	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Ernest Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Ottilie Kriening
15. Birthplace Germany

16 (a) Informant Mr. Ernest L. Hoxter
(b) Address 3103 Orlando Avenue

17 (a) Burial (b) Date thereof 6/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5505 Harford Road -14-

19 (a) JUN 19 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1942 to June 17 1945 and that I last saw her alive on June 17 1945.

Immediate cause of death	Duration
Chr. Myocarditis	3 Yrs
Due to Hypertensive cardio vascular renal disease	3 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S.A. Alessi M.D.
M. D.
Address 6217 Harford Rd Date signed 6/18/45

VS 150

X

G29981

JO #93717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1147

G29981 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Levy Turner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1900

8. AGE: Years	Months	Days	If less than one day
45	4	21	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaiah Turner
13. Birthplace Virginia

MOTHER
14. Maiden Name Liza Boyle (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 1 - 45 (month) (day) (year)
(c) Cemetery or crematory Northumberland Co., Location Virginia
18 (a) Funeral director Mrs. Katie R. Wallin
(b) Address 322 N. Schroeder St.
19 (a) (Signature of registrar) (b) Registrar

JUN 19 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 20, 1945, to June 17, 1945, and that I last saw h im alive on June 17, 1945.

Immediate cause of death: Heart failure — Duration: 2 days
Due to: abscess of the lung — Duration: (?)
Due to: — Duration: over
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 6/19/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29982 — BALTIMORE CITY HEALTH DEPARTMENT — G29982

CERTIFICATE OF DEATH 161a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balt. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr 17 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Stoll Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BABY BOY EIDE

3 (b) If veteran, name war

3 (c) Social Security Account No. (infant)

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-45

8. AGE: Years	Months	Days	If less than one day
			1 hr. 17 min.

9. Birthplace BALIMORE, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name TOBE EIDE
13. Birthplace NORWAY

MOTHER
14. Maiden Name GRACE ALMA FRALICK
15. Birthplace NOVA SCOTIA

16 (a) Informant Grace Alma Eide
(b) Address 1031 Stoll Place

17 (a) Burial (b) Date thereof June 20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Le Hanover
Huntington Ave Baltimore, Md

20 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 10 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 25 PM 6/17 1945 to 10 25 PM 6/17 1945, and that I last saw h[illegible] alive on 6/17 1945.

Immediate cause of death	Duration
A tuberculosis	1 hr 17 min
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Madison Boyer III M. D.
Address South Balt Gen Hosp Date signed 6/17/45

VS 150

X

G29983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

✓ G29983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Coffey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
86 yrs			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Edward Coffey
13. Birthplace Baltimore

MOTHER
14. Maiden Name Johanna Crawley
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street Balt.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-20-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Waszek
(b) Address 20 E 23rd St Baltimore

JUN 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 1945, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1945, to June 17 1945, and that I last saw her alive on June 17 1945.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 6/18/45

X

CERTIFICATE OF DEATH

629984 — 93 DV 629984

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander L. Hunter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose M. Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 10 - 1880

8. AGE: Years 65 | Months 3 | Days 7 | If less than one day min.

9. Birthplace: Balto. Md. (town, county and state)

10. Usual Occupation: Painter

11. Industry or business

FATHER — 12. Name: Wm. G. Hunter

13. Birthplace: Balto.

MOTHER — 14. Maiden Name: Gertrude Goodhues

15. Birthplace: Balto.

16 (a) Informant: Rose M. Hunter

(b) Address: 2704 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 21-45 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park

Location: Windsor Mill Rd.

18 (a) Funeral director: John A. Horan

(b) Address: 1301 Fremont Ave

JUN 19 1945

(b) Registrar

Registered by registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to June 17 1945, and that I last saw h alive on June 16 1945.

Immediate cause of death	Duration
a. Cerebral Hemiplegia.	
Due to Hemorrhage & Softening	
Due to	
Other Conditions Hypertension C.V. disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. E. Needle
23. Signature
Address 1314 - N. Mt. 8th St. Date signed 6/19/45 D.

BALTIMORE CITY HEALTH DEPARTMENT

G29985 ✓ G29985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N Dris an
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N. Dris an (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas L. Regan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Anne J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24—1861

8. AGE: Years 83 | Months 76 | Days 23 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Regan
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Murray
15. Birthplace Ireland

16 (a) Informant Frank J. Regan
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20-45 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Conv. Location Govans Md.

18 (a) Funeral director John J. Madden
(b) Address 800 E. Balto St.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

JUN 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 17 1945, and that I last saw him alive on June 17 1945.

Immediate cause of death	Duration
Chr. Myocarditis	2 days
Hypostatic Pneumonia	several days
Due to Senile Arteriosclerosis	3 & 4 yrs.
Due to Renal Calculi or Pyelitis	4 days
Other Conditions Renal Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. L. Regan M.D.

Address 1938 Linden Ave Date signed 6/19/45

X

P 150

G29986 BALTIMORE CITY HEALTH DEPARTMENT G29986

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Foster Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James M. Arthur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	18	17 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name John Arthur

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden Name Annie F. Gardner

15. Birthplace Baltimore, Md.

16 (a) Informant Mary Meyer

(b) Address 3111 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-45 (month) (day) (year)

(c) Cemetery or crematory Nat. Cath. Location Old Frederick Rd

18 (a) Funeral director John A. Logan

(b) Address 3000 E. Balto St.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 45 3:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Maddox M.D. Medical Examiner.

Date signed June 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ewing ✓ G29987

G29987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133B

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 week

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1331 Lerofton Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Isabella L Ewing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12-1894

8. AGE: Years	Months	Days	If less than one day
50 51	7	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Samuel McLeomb

13. Birthplace Balto. Md

MOTHER

14. Maiden Name Anna McDermott

15. Birthplace Balto. Md.

16 (a) Informant Charles D. Ewing

(b) Address 1331 Lerofton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20-45 (death) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Old Frederick Rd.

18 (a) Funeral director John A. Moran

(b) Address 4201 Fremont Ave

19 (a) (Date received by registrar) (b) Registrar's No.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 18 1945 and that I last saw her alive on June 14 1945.

	Duration
Immediate cause of death Respiratory Failure	
Due to Uremia	
Due to Polycystic Disease of Kidneys	
Other conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. M. Jarrison M. D.

Address University Hosp Date signed 6-18-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. 629988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Filbert St
(c) Hospital or institution: Curtis Bay
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Filbert-Curtis Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Andrew Branham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11th 1922

8. AGE: Years 23 | Months 2 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business B & O R.R.

FATHER
12. Name Pidge Branham
13. Birthplace Va.

MOTHER
14. Maiden Name Irena Hamilton
15. Birthplace Va.

16 (a) Informant Pidge Branham
(b) Address 1519 Filbert St. Curtis Bay

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUN 20 1945 Received by Registrar Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 1945, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 17 1945
and that I last saw alive on June 17 1945

Immediate cause of death	Duration
(a) Myocarditis Luetic	
Due to (b) Pulmonary Tuberculosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos D Dodd M. D.
Address 4240 Date signed June 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G29989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G29989

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 W. 25th st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 W. 25th st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Fannie W. Nelson

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 24th 1876

8. AGE: Years 68 | Months 8 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Self

FATHER
12. Name J. Thomas Nelson
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Octavia A. Luckey
15. Birthplace Harford Co. Md.

16 (a) Informant Grace L. Nelson
(b) Address 227 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery Bethel Presbyterian
Location Madonna Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Filed JUN 29 1945 (b) Registrar's signature Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1945, to June 19 1945 and that I last saw h.. alive on June 9 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Pearce M. D.
Address 2105 Eutaw Date signed June 19/45

G29990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G29990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick G. Witte

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Anna M. Witte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9th 1864

8. AGE: Years	Months	Days	If less than one day
80	9	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name (Unknown) Witte
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Dorothy W. Keller
(b) Address 3614 Elcatn Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JUN 20 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th 1945, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 16 June 1945 to 19 June 1945 and that I last saw him alive on 19 June 1945.

Immediate cause of death	Duration
Generalized Arterio-Sclerosis	
Due to	
Due to	
Other Conditions Renal Insufficiency 4 d	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 2925 N. Charles St Date signed 19 Jun 45

— over —

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

629991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. 629991

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 N. Gilmore Street
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 N. Gilmore Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Waters

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1879

8. AGE: Years 65 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace West River Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name James Waters
13. Birthplace West River Md.

MOTHER
14. Maiden Name Kate Jones
15. Birthplace West River Md.

16 (a) Informant Florence Johnson (Niece)
(b) Address 43 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Chas Gorsuch
(b) Address 512 Cathedral St.

19 (a) JUN 20 1945 (Date rec'd by registrar) (b) Huntington W. Jones M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14- 1945, at 11 45 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intestinal Obstruction

Due to Adenoma

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 6-15-45

G29992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G29992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. Rutland Ave

(c) Hospital or institution: Sinai Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 813 Chauncey Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME VALLENSTEIN, LOUIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Jessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Simon R.

13. Birthplace

MOTHER

14. Maiden Name Ida R.

15. Birthplace

16 (a) Informant Mrs D. Kramer

(b) Address 813 Chauncey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)

(c) Cemetery or crematory Northern Ave

Location

18 (a) Funeral director Jacob Levine Inc

(b) Address 1401 E. Baltimore St

19 (a) (b) Registrar

JUN 20 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to June 20 1945 and that I last saw him alive on June 20 1945

Immediate cause of death Cardio respiratory failure — Duration

Due to Myocardial infarction

Due to Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Rochelin M. D.

Address Sinai Hosp. Date signed June 20

X

G29993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G29993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2878 Mayfield
(c) Hospital or institution: 81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2878 Mayfield (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustav Heid Sr

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jennie Heid

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1876

8. AGE: Years 68 | Months 11/10 | Days 23 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Retired

FATHER 12. Name John Heid

13. Birthplace Germany

MOTHER 14. Maiden Name Dont Known

15. Birthplace Germany

16 (a) Informant Gustav Heid Jr

(b) Address 2878 Mayfield Ave

17 (a) (Burial, cremation, removal) (b) Date thereof Jun 21/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore

18 (a) Funeral director Welsh & Hamilton

(b) Address Huntington Ave & Williams, Md

19 JUN 20 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 9 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1945, to June 18 1945 and that I last saw h alive on June 17 1945

Immediate cause of death Carcinomatosis — Duration

Due to Primary lesion in right lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M. D.

Address 5065 North Ave Date signed 6-18-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) G29994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G29994 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Lyndhurst St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Winter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Alice G. (nee Brokaw) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1868

8. AGE: Years 77 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Baltimore City Schools

FATHER
12. Name Wm. Winter
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Ralph W/ Ferder
(b) Address 511 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21/45 (month) (day) (year)
(c) Cemetery or crematory Winter Cemetery
Location New Windsor, Carroll Co. Md.

18 (a) Funeral director Harry H. Witzke,
(b) Address 4101 Edmondson Ave.

19 (Date rec'd by registrar) JUN 20 1945

Huntington Printing Co.

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18/45. 19 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2. 1945 to June 18 1945 and that I last saw him alive on June 17, 1945

Immediate cause of death: Edema of lungs — Duration: 2 wks.

Due to: Arthritis deformans 30 yrs. — 3 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells. M. D.
Address 4101 Edmondson Ave Date signed 6/19/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 G29995 ✓ G29995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Walnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Grason Stinchberry Stichberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Matilda C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	14	hr. min.

9. Birthplace Easton, Md.
(Town, county, and state)

10. Usual Occupation Electrical Engineer

11. Industry or business General Electric Co.

FATHER
12. Name Wm F. Stichberry
13. Birthplace Md.

MOTHER
14. Maiden Name Sally Smith
15. Birthplace Md.

16 (a) Informant Mrs Matilda Stichberry
(b) Address 1004 Walnut Ave.

17 (a) Burial (b) Date thereof 6/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3800 Frederick Rd

18 (a) Funeral director Harry D Wilkes
(b) Address 4101 E Lanvindon ave

19 (a) JUN 20 1945 (b) Huntington Williams, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 7 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1945, to 6/17 1945, and that I last saw him alive on 6/12 1945.

Immediate cause of death	Duration
Hernia	
Terminal Pneumonia	
Due to	
Due to	
Other Conditions Parkinsons Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hosp. Date signed 6/21/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 Trans G29996

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G29996 ✓ Registered No. G29996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Berlin, Germany

3 (a) FULL NAME Elsie James Mrs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Geo A. James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23. 1881

8. AGE: Years 64 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace Berlin, Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ernest Frank
13. Birthplace Germany

MOTHER 14. Maiden Name Ottila Kreening
15. Birthplace Germany

16 (a) Informant Mr. George A. James
(b) Address 2137 Holden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Old Frederick Rd

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) JUN 20 1945 (Date received by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-45 19 ..., at 630 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1945 to 6-18 1945; and that I last saw her alive on 6-18 1945.

Immediate cause of death Myocardial failure — Duration

Due to Bilat. bronchopneumonia

Due to Gastro-cholecystectomy for Ca of head of Pancreas

Other conditions

(Include pregnancy within 3 months of death)

Date of operation 6-16-45

Major findings of operation: Cancer of head of Pancreas with metastasis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W W Walker M.D.
Address Date signed 6/19/45

X

G29997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G29997 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1850 Penna Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1850 Penna Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearline Blackwell

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	A.A.	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			11 hr. 20 min.

9. Birthplace 1850 Penna Ave, Balt. Md
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Marshall Blackwell
13. Birthplace Gainesville Co., Virginia

MOTHER
14. Maiden Name Hannah Elizabeth Jones
15. Birthplace Eastern Shore, Md

16 (a) Informant Mrs. Hannah Blackwell
(b) Address 1850 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pendra ave

19 (a) JUN 20 1945 (b) Hunting[illegible] Williams, Md
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1945, at 1.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1945 to 6/18 1945 and that I last saw h— alive on 6/18 1945.

Immediate cause of death	Duration
Congenital Galactosemia	11 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carsen C. Johnson M. D.
Address 1850 Penna Ave Date signed 6/19/45

G29998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G29998 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 Wilmer Cort
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Wilmer Cort (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Bland

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widowed

6 (b) Name of husband or wife John.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-11-1875

8. AGE: Years	Months	Days	If less than one day
70	1	6	hr. min.

9. Birthplace Memphis Miss (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Nelson Crowder
13. Birthplace Miss

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace Miss

16 (a) Informant Elizabeth Smallwood
(b) Address 1032 Wilmer Cort

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 22 45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mon. Cem.
Location Baltimore Md

18 (a) Funeral director William A Chapman
(b) Address 916 Pendleton

19 (a) (Date received by Local Registrar) JUN 20 1945 (b) Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 10:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2-1945 to 6-17-1945 and that I last saw h[illegible] alive on 6-16-1945

Immediate cause of death Carcinoma of Uterus-Secondary Metastasis — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W A Chapman M.D.
600 Washington Date signed 6/19

G29999 Schulze ✓ G29999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 E Federal St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 E Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Caroline Schulze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1872

8. **AGE:** Years 72 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Bernard Sturm
13. Birthplace Germany

MOTHER 14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs Marie Pinkas
(b) Address 2231 E Federal St.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 6-20-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave

18 (a) Funeral director Leo G. Leook
(b) Address 1701-03 N Patterson Park ave

19 (a) (Signature or address) Hunting for Witness, MD

JUN 20 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17th 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10, 1945, to June 17 1945, and that I last saw her alive on June 16, 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	7 days
Due to: Arteriosclerosis	7 yrs.
Due to:	
Other Conditions: Right Hemiplegia.	7 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen G. Fingerwald
1613 E. North Ave. Date signed 6-19-45

X

G30000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G30000 Registered No. 3678

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 Ettings St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Ettings (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Brayton
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife James Brayton
6 (c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) 1873
8. AGE: Years 72 | Months | Days | If less than one day ... hr. ... min.
9. Birthplace Essex Co. Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own home

FATHER
12. Name Joseph Upshaw
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant James Brayton
(b) Address 1912 Ettings St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director James A. Stayton
(b) Address 421 N. Whitelock St.
JUN 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1945, at 9:10 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 6-14-1945, to 6-17 1945, and that I last saw her alive on 6-16-1945.

Immediate cause of death	Duration
Cerebral hemorrhage	4 days
Due to Arteriosclerosis + hypertension	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 6-17-45

VS 150

X

G30001 ✓ G30001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 N. Gilmor
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Jennings

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-4435

4. Sex M. | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Beulah Jennings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28-1902

8. AGE: Years 42 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Fairfield, Md
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Wesley Jennings

13. Birthplace Md.

MOTHER 14. Maiden Name Amanda Coleman

15. Birthplace Va.

16 (a) Informant Beulah Jennings

(b) Address 8 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director James A. Dayes

(b) Address 1142 W. Lexington St

19 (a) (Date received by the) (b) Huntington Williams Mortician

JUN 20 1945

MEDICAL CERTIFICATION 6.02

20. DATE OF DEATH June 18 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to June 18 1945; that I last saw alive on June 18 1945

Immediate cause of death	Duration
Coronary occlusion	12 hrs
Due to Carditis	6 Mos
Due to Endo carditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. H. Magruder M. D.

Address 14. E. Read St Date signed 6/20/45

VS 150

✓ X

G30002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G30002 ✓ Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 S.CHESTER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S.CHESTER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE LINDEMAN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: JOHN LINDEMAN
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT.29 1869

8. AGE: Years 75 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: POLAND

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: POLAND

16 (a) Informant: HELEN LINDEMAN (DAUGHTER INLAW)
(b) Address: 6 S.CHESTER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 20/45 (month) (day) (year)
(c) Cemetery or crematory: MT.CARMEL
Location: ODONNELL ST.

18 (a) Funeral director: Lilly and Geiler INC.
(b) Address: 403 S.WOLFE ST.

19 (a) (b) Huntington Williamson M.D.

JUN 20 1945

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH: JUNE 16 1945 at 6/15M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945. to June 16 1945. and that I last saw her alive on June 16 1945.

Immediate cause of death	Duration
Hypostatic pneumonia	2 days
Due to Cerebral accident	4 days
Due to Arteriosclerotic cardio-vascular-renal disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm N. MacFaul Jr M. D.
Address 1800 N. Charles St Date signed 6/18/45

X

G30003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30003
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N. BELNORD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. BELNORD AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY WOLTERS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: HENRY WOLTERS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 21 1873

8. AGE: Years 71 | Months 10 | Days 11 | If less than one day: hr. min. 28

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name JOHN SPIESER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY ALMERDING
15. Birthplace GERMANY

16 (a) Informant MARGARET KIDWELL (DAUGHTER)
(b) Address 102 N. BELNORD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 21/45 (month) (day) (year)
(c) Cemetery or crematory SCHWARTZ CEM.
Location ODONNELL ST.

18 (a) Funeral director Lilly and Buker Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) JUN 20 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18 1945 at 8/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10-1942 to June 18 1945; and that I last saw her alive on June 16 1945.

Immediate cause of death: Myocardial Insufficiency — Duration: 3 days.
Due to: Pulmonary Edema. — 2 yrs.
Due to: Cerebral Thrombosis — Left Hemiplegia
Due to: Chronic Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature M. D.
Address 1561 Mitton Ave Date signed 6/19/45

X

G30004 — BALTIMORE CITY HEALTH DEPARTMENT — Brauns ✓ — G30004

CERTIFICATE OF DEATH 928

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Huffman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Huffman Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Brauns ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife L C August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11871

8. AGE: Years 74 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Henry Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 6/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Rd.
Location Frederick Co. Md.

18 (a) Funeral director Edward Tantum
(b) Address 2359 West Pratt

19 (a) (b)
(Date received by registrar) Registrar

JUN 20 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19/1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19/45 to 6/19/45 and that I last saw he alive on 6/19/45

Immediate cause of death Broncho Pneumonia — Duration 2da.

Due to Hemiplegia Right. — 3yr

Due to Hypertensive Cardio Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G. Lewis M. D.
Address 1905 Huffman Ave Date signed 6/19/45

G30005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G30005
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 Harlem Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Gale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Arthur R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1895

8. AGE: Years	Months	Days	If less than one day
50	-	7	hr. min.

9. Birthplace Princess Ann, Md.. (Town, county, and State)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name George Cornish.
13. Birthplace Princess Ann, Md.

MOTHER
14. Maiden Name Beauford King.
15. Birthplace Princess Ann, Md.

16 (a) Informant Mr. Arthur R. Gale.
(b) Address 909 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Mattie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 29 1945 to June 15 1945 and that I last saw her alive on June 15 1945

Immediate cause of death (a) Lobar Pneumonia — Duration: 1 week
Due to
Due to
Other Conditions Cervical and Axillary Adenitis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S B Hughes M. D.
Address 1413 Druid Hill Ave Date signed June 16/45

VS 3

G30006 BALTIMORE CITY HEALTH DEPARTMENT G30005
Registered No.

CERTIFICATE OF DEATH 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Needum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Maggie Needum

6 (c) If married, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 18[illegible]

8. AGE: Years 56 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Oconee Co. Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Horace Needum

13. Birthplace Oconee Co. Va.

MOTHER 14. Maiden Name White ?

15. Birthplace Oconee Co Va

16 (a) Informant Mrs Mattie Walker

(b) Address 1027 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Anne Arundel Co

18 (a) Funeral director Mrs. Katie B. Williams

(b) Address 322 W. Schroeder St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 1 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to June 17 1945 and that I last saw him alive on June 17 1945

Immediate cause of death Cardio-Vascular renal disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H. Watts M. D.

Address 975 Calvert Ave Date signed 6/20/45

X

G30007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30007

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Provident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 / 24 dys

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 441 W. Biddle St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Negro	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1861

8. AGE: Years	Months	Days	If less than one day
53	5	22	hr min.

9. Birthplace Upper Hill, Md.. (Town, county, and state)

10. Usual Occupation Beauty - Parlor

11. Industry or business

FATHER

12. Name George Maddox.

13. Birthplace Upper Hill, Md..

MOTHER

14. Maiden Name Lucinda

15. Birthplace Somerset Co.

16 (a) Informant Mrs. Mattie Maddox

(b) Address 441 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-45 (month) (day) (year)

(c) Cemetery or crematory

Location Upper Hill, Md..

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 328 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

JUN 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 5 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 17 1945 and that I last saw her alive on June 17 1945

Immediate cause of death Diabetic coma — Duration

Due to Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Howell M. D.

Address 601 Cathedral Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G30008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 N. Pine St.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Pine (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ida Latta

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ernest Latta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1 1910

8. AGE: Years: 34 | Months: 9 | Days: 18 | If less than one day: hr. min.

9. Birthplace Winnsboro S. C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Julian Brodyard
13. Birthplace Kershaw S.C.

MOTHER
14. Maiden Name Frances Crumpton
15. Birthplace Winnsboro, S.C.

16 (a) Informant Ernest Latta
(b) Address 309 N. Pine

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 6-20-'45 (month) (day) (year)
(c) Cemetery or crematory Winnsboro
Location Winnsboro, S.C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroder St

19 (a) (Signature of local registrar) (b) Registrar

JUN 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1944, to June 19 45
and that I last saw her alive on June 18 1945.

Immediate cause of death: Congestive Heart failure — Duration

Due to: Hypertension and Nephritis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. R. Julian, M.D.
Address 434 E. 73rd St Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30009 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elmer Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 25, 190[illegible]

8. AGE: Years	Months	Days	If less than one day
43 44	5	21	hr. min.

9. Birthplace Oriental, N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace N.C

MOTHER
14. Maiden Name Susie Spencer
15. Birthplace N.C.

16 (a) Informant Dorothy Mathews
(b) Address 138 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/45 (month) (day) (year)

(c) Cemetery or crematory
Location Newburn N.C.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bloomingdale Ave

19 (a) (Date received by registrar) (b) Registrar

JUN 20 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16- 1945, at 3 ~~P~~ AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpeis M.D.
Medical Examiner.
Date signed 6-16-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Laurens St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1886

8. AGE: Years	Months	Days	If less than one day
59	4	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Carrie Clarke
(b) Address 1808 Laurens Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1613 Pennsylvania Ave

19 (a) (Date rec'd by registrar) JUN 20 1945 (b) Huntington West Virginia, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18/45, at 4 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

(e) Signature Ruth F. Mitchell M.D.
Medical Examiner.

Date signed 6/19/45

VS 151

G30011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30011 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 Orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give Co.)
(d) Street No. 1438 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Kate Fowler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Fowler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1861

8. AGE: Years 84 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER
12. Name James Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Wilson
15. Birthplace Md.

16 (a) Informant Cora Saunders
(b) Address 1438 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Central Ave

19 (a) [illegible] (Registered by registrar) JUN 20 1945 (b) Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1945, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945, to June 18 1945 and that I last saw him alive on June 12 1945

Immediate cause of death Cerebral Hemorrhage — Duration 4 Mos.

Due to Hypertensive Cardio Vascular Disease — 1 Yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. K. Adams M. D.
Address 1222 N. Carolina Date signed 6-20-45

X

G30012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Eden Street (If rural, give location)
(e) Citizen of foreign country? Eden (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Blunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name not known
13. Birthplace " "

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant Alfred Jones
(b) Address 825 Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mt Calv
Location Edwy O Wilson

18 (a) Funeral director
(b) Address Wood Brantley

19 (a) JUN 20 1945 Huntington Williams, Registrar, M.D.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945, at 7:50 P. M

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion
cardio-vascular-renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed June 15, 1945.

G30013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G30013 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton & Wilkens Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1917 Forest Pk (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Quimby

3 (b) If veteran, name war C

3 (c) Social Security Account No. C

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-26-1944

8. AGE: Years 1 Months 5 Days 18 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER 12. Name Harvey Quimby

13. Birthplace Easton Md

MOTHER 14. Maiden Name Mary Helen Hoffinger

15. Birthplace Easton Md

16 (a) Informant Harvey Quimby

(b) Address 1917 Forest Pk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 1945 (month) (day) (year)

(c) Cemetery or crematory St Marys

Location Elchester Md

18 (a) Funeral director Wendell Chappel

(b) Address 312 S. Highland Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 20 1945 Huntington Wilson

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1945 to 6/18 1945 and that I last saw him alive on 6/18 1945

Immediate cause of death	Duration
Heart Failure	
Due to Acute Fulminating Bilateral Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Cliff Rathiff Jr. M. D.

Address St Agnes Hospital Date signed 6/18/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G30014

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Florence Pilmer

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. **AGE:** Years 80 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name .....
13. Birthplace

MOTHER
14. Maiden Name .....
15. Birthplace

16 (a) Informant Wendell Hoppel
(b) Address 312 S. Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 1940 (month) (day) (year)
(c) Cemetery or crematory St Wallpas
Location O'Donnell St

18 (a) Funeral director Wendell Hoppel
(b) Address 312 S Highland Ave

19 (a) ..... (b) .....
(Date rec'd by registrar)

JUN 20 1940

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1945 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature C. P. Sutinaki M.D.
Medical Examiner.

Date signed 6/16/45

G30015 BALTIMORE CITY HEALTH DEPARTMENT G30015
Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 W. Bare ST Pasadena Rd (Give number and street or R.F.D. route number) md
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Richards (Johnson)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-31-45 1929

8. AGE: Years	Months	Days	If less than one day
16	1	8	hr. min.

9. Birthplace A. A. County Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Nanna Richards
15. Birthplace Md

16 (a) Informant Nina Le Compte
(b) Address 608 W. Bare St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-45 (month) (day) (year)
(c) Cemetery or crematory Magothey Cem:
Location G. A Cemetery

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945; at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Chronic nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gutman M.D.
Medical Examiner.
Date signed June 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47a

G30016

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 S. Robinson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Robinson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Welk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Irena L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13-1886

8. AGE: Years 58 59 | Months 10 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business Schuylkill Knitting

FATHER
12. Name Francis Welk
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Anna Evans
15. Birthplace Phila. Pa.

16 (a) Informant Irene L. Welk
(b) Address 131 S. Robinson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Co.

18 (a) Funeral director John G. Forman
(b) Address 300 E. Balto. St.

19 (a) [illegible] Registrar

JUN 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 6 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1942 to June 18 1945. and that I last saw h alive on June 18 1945.

Immediate cause of death: Carcinoma of Larynx — Duration 2-16-42

Due to

Due to None

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation July 1942

Major findings of operation: Carcinoma of Larynx — Permanent Tracheotomy

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eichenwald M. D.
Address 842 S. Ext Ave Date signed 6-19-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G30017

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Longwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Longwood St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Rebecca Cook.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband ~~or wife~~ James Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1870

8. AGE: Years	Months	Days	If less than one day
74	6	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Freeman Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Augusta Legg.
15. Birthplace Md.

16 (a) Informant Katherine Marlow
(b) Address 1411 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director F.C. Higinbothom
(b) Address Edmondson City Md

JUN 20 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19 1945 at 12 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1944 to 6-9 1945 and that I last saw her alive on 6-18 1945.

Immediate cause of death Heart exhaustion — Duration a few hours
Due to Chronic Interstitial Nephritis — unknown
Due to Arthritis Deformans — unknown
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chester Riland, M.D.
Address 2532 Edmondson ave Date signed 6-19-45 M. D.

X

G30018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 782

G30018 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 896 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gary Roberts

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1943

8. AGE: Years 1 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Paul F. A. Roberts
13. Birthplace Illinois

MOTHER
14. Maiden Name Violet E. Miles
15. Birthplace Washington, Indiana

16 (a) Informant Mrs. Violet E. Miles
(b) Address 896 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery or crematory St Johns Cem.
Location Washington, Indiana

18 (a) Funeral director John F. Cowan & Son
(b) Address 90-03 Gallows St.

19 (a) Filed (b) Registrar
by [illegible] Huntington Williams, M.D.

JUN 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 1945, at 2:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1945 to 6/19 1945, and that I last saw him alive on 6/19 1945.

Immediate cause of death Resp Failure — Duration

Due to Pneumonia

Due to

Other Conditions Lead Poisoning

Toxic due to dehydration & vomiting

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. F. Moseley Jr. M.D.
Address Univ Hosp. Date signed 6/19/45

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G30019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30019

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2424 Callow Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13+

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2424 Callow Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Cecil Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife C. Julia Shaw Evans

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) September 1, 1871

8. AGE: Years	Months	Days	If less than one day
73	9	17	hr min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business City of Baltimore

FATHER

12. Name Henry Montagu Evans

13. Birthplace England

MOTHER

14. Maiden Name Mary Cavanaugh

15. Birthplace England

16 (a) Informant Mr. P. Shaw

(b) Address 2424 Callow Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21,1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18 (a) Funeral director Phillip Lawrence

(b) Address 4520 Liberty Heights Ave.

19 (a) JUN 20 1945 (Date rec'd by registrar)

Huntington for Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1943, to June 18 1945, and that I last saw h. im alive on Apr 3 1945.

Immediate cause of death Coronary Thrombosis — Duration abt 3 days

Due to Renal arteriosclerosis and

Due to Diabetes mellitus

Other Conditions Secondary anemia and B12 deficiency

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 12 E. Eager St. M. D. Date signed June 19/45

G30020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30020

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1004 Harford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1004 Harford Ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Annie M. Young

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry S. Young

6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.) May 30, 1874

8. AGE: Years: 71 | Months: 0 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Phila. Pa. (Town, county, and state)

10. Usual Occupation: House work

11. Industry or business: at Home

FATHER

12. Name: James Flanagan

13. Birthplace: Ireland

MOTHER

14. Maiden Name: Ellen Flagan

15. Birthplace: Ireland

16 (a) Informant: Henry S. Young

(b) Address: 1004 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/45 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: 4439 Belair Rd

18 (a) Funeral director: Edwin W. Confer

(b) Address: 9242 Eager St

19 (a) (Date rec'd by registrar) JUN 20 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1945 to 6/18 1945, and that I last saw h[illegible] alive on 6/14 1945.

Immediate cause of death	Duration
Acute Coronary infarction	
Due to Coronary Sclerosis	
Due to Ch. Myocarditis	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. L. Homatemi M. D.

Address 733 Augusta St Date signed 6/20/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G30021
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3123 Mc Elderry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town xxx Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Mc Elderry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Winifred Deckelman

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick Deckelman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1894

8. AGE: Years 50 | Months 6 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Feehly
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Smith
15. Birthplace Baltimore Md

16 (a) Informant Frederick Deckelman Md
(b) Address 3123 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Eastern Avenue

18 (a) Funeral director Albert L Nitz Jr
(b) Address 1606 Manchester Street

19 (a) JUN 20 1945 (Date rec'd by registrar) (b) Registrar

Huntington for Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 3 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11, 1945, to June 18 1945, and that I last saw h alive on June 18, 1945.

Immediate cause of death
Diabetes Gangrene of foot — Duration 3 weeks
Due to Diabetes Mellitus — Duration 7 yrs.
Due to — Duration
Other Conditions Anemia — Duration 2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex E Sokoloff M. D.
Address 2939 Orleans Date signed 6/19/45

G30022 G30022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State. Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Helsel

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-45

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Baltomore, Maryland
(Town, county, and state)

10. Usual Occupation Infant
11. Industry or business none

FATHER
12. Name John Henry Helsel
13. Birthplace Ohio

MOTHER
14. Maiden Name Ruth Dishong
15. Birthplace Everett, Penn.

16 (a) Informant Mother - Ruth Helsel
(b) Address 1420 W. Pratt St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 20 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 16 1945, and that I last saw her alive on June 16 1945.

Immediate cause of death Congenital Atelectisis of the Left Lung — Duration: 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Kegerreis M. D.
Address 7n 3q. Hosp. Date signed 6-17-45

X

G30023 G30023

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Doctors Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Eutaw Place (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Musich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
2 days.		2	hr. min.

9. Birthplace Doctors Hospital (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name Betty Musich
15. Birthplace Pocahontas Va.

16 (a) Informant .....
(b) Address 2006 Eutaw Place

17 (a) ..... (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address .....

JUN 20 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17-45 19.. at 5:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.., and that I last saw h..... alive on ..... 19..

Immediate cause of death: Atelectasis — Duration 2 days

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Louis J. Glanz M. D.
Address 526 Arlington Ave Date signed

2773 × 6/18/45

G30024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

G30024

MARGIN RESERVED FOR BINDING. The Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~
(c) Hospital or institution: West Balt. Gen. Hospl.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~
(c) City or town Baltimore #18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 E. 30th St. (If rural give location)
(e) Citizen of foreign country? ~ (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: wh. k

6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife —

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) 6/5/43

8. AGE: Years | Months | Days: 11 | If less than one day: hr. ~ min.

9. Birthplace West Balt. Gen. Hospl. (Town, county, and state)

10. Usual Occupation ~

11. Industry or business —

FATHER
12. Name John Francis Harrison
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Grace Gresenth
15. Birthplace Maryland

16 (a) Informant ~
(b) Address

17 (a) ~ (Burial, cremation, or removal) (b) Date thereof ~ (month) (day) (year)
(c) Cemetery or crematory ~
Location ~

18 (a) Funeral director ~
(b) Address ~

19 (a) JUN 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

UNIVERSITY MEDICAL SCHOOL JUN 18 1945
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 19 41, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 19 41 to 6/16 19 41.
and that I last saw h[illegible] alive on 6/16 19 41.

Immediate cause of death Premature Duration ~

Due to Toxemia of pregnancy of mother.

Due to ~

Other Conditions ~

(Include pregnancy within 3 months of death)

Date of operation ~

Major findings of operation: ~

of autopsy: ~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~ (Specify type of place)
(e) Means of injury ~
23. Signature A. Shepherd M. D.
Address West Balt. Gen. Hospl. Date signed 6/16

VS 150

2.75

X

G30025

475279.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1155

G30025 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution JOHNS HOPKINS HOSPITAL 13-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 913 W. 37th St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Daisy B. Martin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Wm E. Martin

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 1-26-87

8. AGE: Years 58 Months 7 Days 22 If less than one day hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name Gilbert William Albaugh

13. Birthplace Md.

MOTHER

14. Maiden Name Sarah Morrison

15. Birthplace Md.

16 (a) Informant Rhonda

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Maryland

18 (a) Funeral director Burgie Funeral Home

(b) Address 3231 Falls Road Baltimore, Md.

19 JUN 20 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 1020 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 18 1945, and that I last saw h[illegible] alive on June 18 1945.

Immediate cause of death Paget's disease of Skull - post operative.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/16/45

Major findings of operation: Paget's Disease of Skull - platybasia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ben Alexander, M.D.

Address Johns Hopkins Hosp. Balto. Md. Date signed 6/19/45

VS 150

G30026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G30026

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Bayonne Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Gehring

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	widower

6 (b) Name of husband or wife Mary E. Gehring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-23-1859

8. AGE:	Years	Months	Days	If less than one day
	85	7	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None retired
11. Industry or business

FATHER
12. Name John Gehring
13. Birthplace Germany

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Miss Bernardine Gehring
(b) Address 4311 Bayonne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 305 Harford Rd.

19 (a) (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 20 1945 and that I last saw h ive alive on June 20 1945

Immediate cause of death	Duration
Cardiac failure	2 days
Bronchopneumonia	
Due to Arteriosclerotic CVD	
Due to	
Other Conditions Ca of Recto-Sigmoid Acute intestinal obstruction (Include pregnancy within 3 months of death)	

Date of operation June 12, 1945
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy B. Turner, Jr. M. D.
Address Mercy Hosp Date signed 5/20/45

VS 150

X

Dr. Bac 630027
Taylor Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30027
Registered No. 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 Berwick Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Berwick Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Bachman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Henry A. Bachman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1858

8. AGE: Years 86 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name August Herkenburg
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Henkell
15. Birthplace

16 (a) Informant Mrs. Bertha E. Durm
(b) Address 2714 Berwick Aveue -14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Registrar

JUN 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1940, to June 16 1945, and that I last saw her alive on June 16 1945.

Immediate cause of death: Chronic myocarditis
Due to: Chronic interstitial nephritis
Due to: Arteriosclerosis

Other Conditions: Fracture, left hip. (Include pregnancy within 3 months of death) — 60 days

Date of operation none
Major findings of operation: —
of autopsy: —

Duration: remote / " / " / 60 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 28, 1945 at A. M
(c) Where did injury occur? 2714 Berwick Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fell out of bed.

23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave. Date signed 6/19/45

For H. B. McCurdy, by Howard J. Malden, M.D.

G300228 — BALTIMORE CITY HEALTH DEPARTMENT — G300228

CERTIFICATE OF DEATH 1945

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 John St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) = 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 John St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Rose Herzog

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W Latv | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Adam Herzog
13. Birthplace

MOTHER
14. Maiden Name Adele Uhlenbrog
15. Birthplace Germany

16 (a) Informant Mr. R Herzog
(b) Address Ft. Charles St

17 (a) Cathedral (Burial, cremation, or removal) (b) Date thereof 6-22-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location —

18 (a) Funeral director Mary M Wedefield
(b) Address 501 E. 22nd St

19 (Date received by registrar) JUN 20 1945 (Courtenay Tor Williams M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1945 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic
CVD
Due to senility
Other Conditions none
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Thuston M.D. Medical Examiner.
Date signed 6/19/45

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 596

G30029
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 Barclay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA L. WHITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Dr. T.S. Whittle
13. Birthplace Maryland

MOTHER
14. Maiden Name B. O'Brien
15. Birthplace Ireland

16 (a) Informant Miss F. Whittle
(b) Address 2526 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location

18 (a) Funeral director May W Medsfield
(b) Address 501 East 22nd Street

19 (a) 1945 (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 1945, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943, to June 16 1945, and that I last saw her alive on June 16 1944.

Immediate cause of death Pneumonia
Hypostatic

Due to

Due to arteriosclerosis

Other Conditions Arthritis. Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 days
?
5 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances Whittle M. D.

Address 1229 N. Calvert Date signed June 20, 1945

Huntington Williams, MD

97

G30030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30030 Registered No.

TM. 91612

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months & 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Salvation Army (No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Hanson Dittus

3 (b) If veteran, name war (0)

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9th 1881

8. AGE: Years 63 | Months 8 | Days 8 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John L. Dittus

13. Birthplace Holland

MOTHER

14. Maiden Name Sophia Wakland

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/21/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 E. Fort Ave.

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 17th 1945, at 3.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1945, to June 17 1945, and that I last saw him alive on June 17 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to Cerebral arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Examined

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 6-20-45

VS 150

G30031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G30031

CWK-72609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 3- 0-
(e) Length of stay in Baltimore (yrs., mos., or days) 77- 7- 8-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Thames Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Benninger

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Joseph Benninger (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9-1867

8. AGE: Years	Months	Days	If less than one day
77	7	8	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Charles Brown
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann Patterson
15. Birthplace ???

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 129 E Saratoga St

19 (a) [illegible] (b) [illegible] Huntington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to June 17 1945, and that I last saw her alive on June 17 1945.

Immediate cause of death: Cachexia

Due to: Adeno-carcinoma Gall bladder — metastatic

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4-19-45

Major findings of operation: Adeno-Carcinoma of gall bladder metastatic

of autopsy:

Duration: ? ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard E. Bolton M.D.
Address City Hosp. Date signed 6/19/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 19

G30032 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital 9 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 E. Preston St. 6 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard L. Harkins

3 (b) If veteran, name war: N

3 (c) Social Security Account No. 216-01-1024

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Victoria

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 14 1882

8. AGE: Years	Months	Days	If less than one day
63	1	4	hr. min.

9. Birthplace McKeesport Pa. (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business National Lead Co.

FATHER 12. Name Daniel Harkins

13. Birthplace Pa.

MOTHER 14. Maiden Name Catherine (Unknown)

15. Birthplace "

16 (a) Informant Victoria Harkins

(b) Address 816 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Lafayette & Mt

18 (a) Funeral director Tilhom & Son Inc

(b) Address 1217 H Pont St

19 (a) (b)
(Date received by registrar) (Registrar)

JUN 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 19 45 at 12:10 M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/17 19 45 to 6/19 19 45
and that I last saw him alive on 6/19 19 45

Immediate cause of death Heart Failure — Duration

Due to Adhesions Disease (Acute Obstruction) — 1 year

Due to Generalized Glandular Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Generalized Glandular Tb

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jeff Ratliff Jr. M. D.

Address St. Agnes Hosp. Date signed 6/19/45

M. D. R. 1268-0

G30033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

131a G30033

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1322 N. Mount St., 7 Ward)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds. 5

2. FULL NAME Bessie Elizabeth Hill

(a) Residence: No. 1322 N. Mount St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert Hill

6. DATE OF BIRTH (month, day, year) Dec 1, 1874

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ...

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Robert Hill

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Bessie E.

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Joseph F. Hill
(Address) 1322 N. Mount St.

18. BURIAL, CREMATION, OR REMOVAL
Place New Cathedral Date June 22 19 45

19. UNDERTAKER Charles K. Law
(Address) 802-04 Madison Ave.

20. JUN 21 1945 19... Huntington Willis, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 18, 1945

22. I HEREBY CERTIFY, That I attended deceased from May 16, 1945 to June 18, 1945

I last saw h.er alive on June 18 1945 Death is said to have occurred on the date stated above, at 7.45 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio vascular renal disease	12-14-43

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in, also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
no If so, specify ...

(Signed) John E. L. Camper M. D.
(Address) X

R—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G30034 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Lakeland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Lakeland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Schmider or Smieder

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jean C. Schmider

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1900

8. AGE: Years	Months	Days	If less than one day
45	3	0	hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Supervisor

11. Industry or business: American Export Line

FATHER
12. Name: Frank Schmider or Smieder
13. Birthplace: Poland

MOTHER
14. Maiden Name: Emma Levendoski
15. Birthplace: Poland

16 (a) Informant: Mrs. Jean C. Schmider
(b) Address: 2500 Lakeland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Natl. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date filed by registrar) JUN 21 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1945; at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 6-19-45

G30035 ✓ G30035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2203 Orem Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 14

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2203 Orem Ave.
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME JOHN F. FREED

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	188-09-2148 B

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Freed

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 19, 1872

8. AGE: Years	Months	Days	If less than one day
73	2	0	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Mattress Maker (Retired)

11. Industry or business

FATHER

12. Name Frederick Freed

13. Birthplace Unknown

MOTHER

14. Maiden Name ? Brown

15. Birthplace Unknown

16 (a) Informant Mrs. Mary E. Freed

(b) Address 2203 Orem Ave.

17 (a) Burial (b) Date thereof 6/21/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUN 21 1945 (b) Huntington Wittington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1945, at 10:15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from about one year 1944 and that I last saw h[illegible] alive on 6-19 1945.

Immediate cause of death	Duration
(a) Chronic Myocarditis + Acute Bronchitis	yrs
Due to (b) (Bronch.)	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature N. C. Howard

Address 923 W. Mulberry St. Date signed 6/20/45

VS 150

Approved - Howard J. Wiedeking M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G30036

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.H.
(b) Street address 604 N. Appleton St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer R Manuel (Manuel)

3 (b) If veteran, name war X

3 (c) Social Security Account No. X

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife X

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/11/1882

8. AGE: Years 61 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Insurance agent

FATHER
12. Name William E Manuel
13. Birthplace West Virginia

MOTHER
14. Maiden Name Clara V Webb
15. Birthplace West Virginia

16 (a) Informant Mrs Agatha Ring
(b) Address 604 Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23-45 (month) (day) (year)

(c) Cemetery or crematory Wenlock Cem.

Location

18 (a) Funeral director Charles P Towell
(b) Address 1437 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945, at 10 40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Signed 6/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134B

G30037

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Red Wood & Greene
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo-Hosp
(e) Length of stay in Baltimore (yrs., mos., or days) Same.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. RFD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georg Welk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Irene

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Aug. 30 1866

8. AGE: Years 78 | Months 9 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Farmer.

11. Industry or business

FATHER
12. Name Henry Welk
13. Birthplace Md.

MOTHER
14. Maiden Name Sevilla Starner
15. Birthplace Md.

16 (a) Informant Mr Harry Welk
(b) Address Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 1945 (month) (day) (year)
(c) Cemetery or crematory Baust Cem.
Location Long Lane near Westminster Md.

18 (a) Funeral director H Bankard Son
(b) Address Westminster Md.

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21 1945, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19... to 19...
and that I last saw him alive on 6-20- 1945.

Immediate cause of death — acute prostatic - bladder stones - benign prostatic
Due to hypertrophy - Uremia

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-11-45
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature DW Minter M. D.
Address Univ. Hospital Date signed 6-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30038
475429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G30038
Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Eckstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Isabel.

6 (c) If alive, give age 37. years

7. Birth date of deceased (mo., day, yr.) 12-1-07.

8. AGE: Years 37. | Months - | Days 17 | If less than one day: hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Frank. Eckstein
13. Birthplace pa.

MOTHER
14. Maiden Name Anna Miller
15. Birthplace Pa

16 (a) Informant Records.
(b) Address [redacted]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Royal, Pa.
Location

18 (a) Funeral director Wm. Calvert M. Stallard
(b) Address 1631 Druid Hill Ave

19 (a) (Date received by registrar) (b) Registrar

JUN 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 18 - 1945, at 8.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June - 13 1945, to June - 18 1945, and that I last saw him alive on June - 18 1945.

Immediate cause of death Subarachnoid. Vascular Rupture and Hemorrhage

Due to Vascular Deformity.

Due to Hypertension.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot Meeman M. D.
Address Huntington Williams, M.D.
Date signed 6/19/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. ✓ H 30039

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Alexander Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1861

8. AGE: Years 84 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Pikesville, Md. (Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER
12. Name Samuel Ford
13. Birthplace Pikesville, Md.

MOTHER
14. Maiden Name Alethia Allen
15. Birthplace San Antonio, Texas

16 (a) Informant Melvest A. Ford
(b) Address 1902 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lenna A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

JUN 21 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945, to June 19 1945, and that I last saw him alive on June 19 1945.

Immediate cause of death Coronary thrombosis — Duration Instantaneous

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Shinall M. D.
Address 1534 Druid Hill Ave Date signed June 21

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G30040

Registered No. 6698

6300-41

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1717 Etting St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 None

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 Etting St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Maria Nelson

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widowed

6 (b) Name of husband or wife Cyrus Nelson (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75			18	10

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Own home

FATHER

12. Name Fleet McCoy

13. Birthplace Virginia

MOTHER

14. Maiden Name Unknown

15. Birthplace Va

16 (a) Informant Christopher Nelson

(b) Address 1717 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Wm. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15- 1944 to 6-18- 1945 and that I last saw her alive on 6-17- 1945.

Immediate cause of death	Duration
Myocarditis	unknown
Due to	
Due to	
Other Conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank H Saunders M. D.

Address 129 N. Stricker St. Date signed 6-18-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G30041 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 E. Preston St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 E. Preston St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME: Mary Agnes Meredith
3 (b) If veteran, name war: ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ##### Ernest Meredith
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	17	--- hr. ---- min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Thomas Fahey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cecelia Cavanaugh
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Ernest Meredith
(b) Address 416 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. F. Mura & Son
(b) Address 805 N. Calvert St.

19 (a) JUN 21 1945 (Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945 to June 19, 1945 and that I last saw her alive on June 18 1945.

Immediate cause of death Carcinoma of the Stomach, with metastases in gall bladder and liver. — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. L. Wilkinson M. D.
Address 5713 Bel Air Rd. Date signed 6-21-45
Balto.

VS 130

G30042 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G30042

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 218 N. Monroe ave St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Annie H. Smith — If U. S. Veteran specify WAR

(a) Residence: No. St., Ward. (If non-resident give city or town and State)

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	W	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Smith

6. DATE OF BIRTH (month, day, year) May 29/1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	-	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME unknown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Harriett Harris

16. BIRTHPLACE (city or town) (State or country) Balto. Md.

17. INFORMANT Albert H. Hammond (Address) 1317 N. Caroline st

18. BURIAL, CREMATION, OR REMOVAL Place Loudley Md Date 6/21/1945

19. UNDERTAKER Elroy L. Wilson (Address) 1000 Brantley ave

20. FILED JUN 21 1945 19..... Registrar.

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 17, 1945

22. I HEREBY CERTIFY, That I attended deceased from 5/28 1945 to 6-17, 1945

I last saw h[illegible] alive on 6-17 1945. Death is said to have occurred on the date stated above, at 6 55/60 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	6/10/45

Other contributory causes of importance:

Chronic Myocarditis	P.

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Calvin B. LeCompte M. D.

(Address) 1117 N. Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V.S.B.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G30064~~ G30063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G30064~~ Registered No. G30063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 N. Stricker ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 N. Stricker ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monroe Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: =

6 (b) Name of husband or wife: Sarah C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19

8. AGE: Years 37 | Months 7 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Darlington Co. S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Johnson.
13. Birthplace Darlington, S.C.

MOTHER
14. Maiden Name Ella Baskins.
15. Birthplace S.C.

16 (a) Informant Mrs. Sarah Johnson.
(b) Address 1111 N. Stricker St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-21-'45 (month) (day) (year)

(c) Cemetery or crematory
Location Florence, S. C.

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) (Delivered by registrar) (b) JUN 21 1945 Hunter for Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945; at 5-40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G300 44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 P

G300 44

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Halethorpe (If outside city or town limits, write RFD, box, and give town)

(d) Street No. 1921 North East Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No). If yes, name country

3 (a) FULL NAME Daisy Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Color

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-1893

8. AGE: Years 52 | Months | Days | If less than one day hr min.

9. Birthplace Person, N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name David Long

13. Birthplace Person, N.C.

MOTHER

14. Maiden Name Amanda Talley

15. Birthplace Person, N.C.

16 (a) Informant Eunice Bryant.

(b) Address 4401 Spring Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-'45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs. Nathan R. Williams

(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) JUN 21 1945 Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH June 16 1945 at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12- 1945 to June 16 1945 and that I last saw h- alive on June 16 1945

Immediate cause of death

Carcinoma

Due to (Uterus)

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation Nov. 1944

Major findings of operation: Johns Hopkins Carcinoma Uterus

of autopsy:

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E.H. Mahoney M.D.

Address Catonsville, Md. Date signed 6/18/45

Huntington Williams, M.D.

~~G30086~~ G30045 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 937

Registered No. G30045

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 677 Sarah Ann (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1897

8. AGE: Years 53 | Months — | Days — | If less than one day hr. — min.

9. Birthplace Lancaster Co S.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Isaac Cunningham

13. Birthplace S.C.

MOTHER 14. Maiden Name Jane Booker

15. Birthplace S.C.

16 (a) Informant Alma Haggans

(b) Address 619 Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location L. A. Co. Md.

18 (a) Funeral director Robert Williams

(b) Address 15-15 McElderry St.

19 (a) JUN 21 1945 Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1945 to 6/16 1945, and that I last saw her alive on 6/16 1945

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertensive Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Howard M. D.

Address 1911 Carrollton Ave Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G30057~~ G30036 BALTIMORE CITY HEALTH DEPARTMENT ~~G30036~~

CERTIFICATE OF DEATH 12B

Registered No. G30036

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Nathaniel Merrill

3 (b) If veteran, name war: U.S. Navy, between Wars
3 (c) Social Security Account No. 063-18-2195

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divirced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1903

8. AGE: Years	Months	Days	If less than one day
42 ~~Yrs~~	-	14	hr. min.

9. Birthplace Temple, Franklin Co., Maine (Town, county, and state)
10. Usual Occupation U. S. Maritime Service
11. Industry or business shipping

FATHER
12. Name Charles Merrill
13. Birthplace New Hampshire

MOTHER
14. Maiden Name Viola Nile
15. Birthplace Rangeley, Maine

16 (a) Informant Mrs. Roxene Millett (Sister)
(b) Address Strong, Maine

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-1945 (month) (day) (year)
(c) Cemetery or crematory
Location Farmington, Maine
18 (a) Funeral director Leo G. Lovell
(b) Address 1701-03 N. Patterson Park Ave
19 (a) (Date received by registrar) JUN 21 1945 Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 6:20 ~~A~~ M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed June 14 1945

(OVER)

G30047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30047

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4315 Springwood Ave
(c) Hospital or institution:
d Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Springwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James F. Rock
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 1st 1863
8. AGE: Years 81 Months 6 Days 18 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Gas & Electric Co
FATHER 12. Name Patrick Rock
13. Birthplace Ireland
MOTHER 14. Maiden Name —
15. Birthplace Ireland
16 (a) Informant Mrs L. Myers
(b) Address 4315 Springwood Ave
17 (a) Burial (Burial, cremation, removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave
18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N Patterson Park ave
19 (a) (b) (Date received by registrar) JUN 21 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19th 1945, at 1:50 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945 to 6/19 1945 and that I last saw him alive on 6/18 1945.

Immediate cause of death: Myocardial Degeneration — Duration 5 Yrs +
Due to: Arteriosclerotic Heart Disease — "
Due to — —
Other Conditions: Anemia, type undetermined; Senility — Unknown
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John W Mackenzie
Address 6304 Belvista Date signed 6/19/45 M. D.

X

~~G30049~~ BALTIMORE CITY HEALTH DEPARTMENT ~~G30049~~

G30048 CERTIFICATE OF DEATH 939

Registered No. G30048

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1371 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter H. Graves

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Daisey M. Graves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 - 1886

8. AGE: Years 59 | Months 7 | Days 17 | If less than one day hr. min

9. Birthplace St. Mary's Co. Md. (Town, county and state)

10. Usual Occupation Inspector

11. Industry or business Baltimore Transit Co.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Louis M. Graves
(b) Address 437 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23-45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location D. C. Co. Md.

18 (a) Funeral director Flynn & Flanigan
(b) Address 1426 Light St.

19 JUN 21 1945 (Date received by Registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 - 1945, at 1:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30-1945 to 6-20 1945, and that I last saw h[illegible] alive on June 19, 1945.

Immediate cause of death Cerebral Accident — Duration 1/2 hr.

Due to Myocardial Degeneration — 2 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Solomon Sherman

Address 2424 Eutaw Place Date signed 6-21-45 M. D.

SOLOMAN SHERMAN M.D.

G30049
~~G300-0~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G300-0~~ Registered No. G30049

160c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calv. & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore county
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Taylor Ave Mercy Hosp. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Wolfe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race W.
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-45

8. AGE: Years | Months | Days | If less than one day 12 HRS min.

9. Birthplace Mercy Hosp. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Irvin Wolfe
13. Birthplace Baltimore

MOTHER
14. Maiden Name Eleanor D. Wolfe
15. Birthplace Balt.

16 (a) Informant mother
(b) Address 1005 Taylor Ave. Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 21 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Fulton Ave & B.S. Wolfe

18 (a) Funeral director Ft & B.S. Wolfe
(b) Address

19 JUN 21 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-20 1945 at 2 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 19 45 to June 21 19 45 and that I last saw deceased alive on June 21 19 45

Immediate cause of death Cardio respir. failure — Duration

Due to Cong. Cerebral hem. overlap

Due to

Other Conditions Congenital birth - Cesarean Section

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Beer M. D.
Address Mercy Hosp. Date signed 6-21-45

VS 150

G30050

Dr. Jacob G30050
1700 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Elizabeth Busch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Andrew C. Busch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1855

8. AGE: Years	Months	Days	If less than one day
89	10	9	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: George Kuhn
13. Birthplace: Germany

MOTHER
14. Maiden Name: Pauline Kuhn
15. Birthplace: Germany

16 (a) Informant: Mr. John A. Busch
(b) Address: 4315 Harcourt Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road

19 (a) (b) Registrar
(Filed by registrar)

JUN 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th, 1945, at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945, to June 18 1945, and that I last saw her alive on June 18 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Hypertension — Advanced Atherosclerosis
Due to:
Other Conditions: Chr. nephritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Louis Busch M. D.
Address 1700 Eutaw Place Date signed June 20-1945

(17) X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

826

Registered No. G30051

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3150 Frederick ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3150 Frederick ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Strasburg

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ellen Strasburg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 - 1863

8. AGE: Years 81 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Carroll Co Maryland.
(Town, county and state)

10. Usual Occupation Tinner - Plumber.

11. Industry or business Retired

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs Marie E Getz
(b) Address 3150 Frederick ave - Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24-1945 (month) (day) (year)

(c) Cemetery or crematory Mountain View Cem.
Location Elkins Bridge Md

18 (a) Funeral director D. D. Hartzler & Son
(b) Address Elkins Bridge & New Windsor Md

JUN 22 1945
(Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1945 at 12 45 P

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to 6/22 1945
and that I last saw him alive on 6/22 1945.

Immediate cause of death	Duration
Cerebral Thrombus	6 days
Due to Arteriosclerosis	
General.	
Due to	
Other Condition Rt sided hemiplegia	3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Duncan Palagia M.D.
Address 336 Reisterstown Rd Baltimore Md
Date signed 6/23/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30052 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 Glenwood Ave
(c) Hospital or institution: Govans

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Glenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Josephine Ann Norman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 87 86 | Months — | Days — | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Robert Edwards
13. Birthplace Virginia

MOTHER
14. Maiden Name S. Efford
15. Birthplace Virginia

16 (a) Informant Leonard Vernon
(b) Address 1002 Glenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 24 1945 (month) (day) (year)
(c) Cemetery or crematory Home Burying Ground
Location Home Place Virginia

18 (a) Funeral director Maynard Wheatley
(b) Address 501 E. 32nd St

JUN 22 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20/1945, at 1330 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20/1945 to 6/20/1945, and that I last saw h alive on 6/20/1945.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 hour.

Due to: Arteriosclerosis Generalized — Duration: 2 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J White M. D.
Address 682 E. 22nd St. Date signed 6/24/45

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C30053

HEP-94182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C30053

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town) Admitted Hotel
(d) Street No. 344 Mason Court
Fayette & Gilday (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore F. Grell

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 579-26-4199

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1898

8. AGE: Years 47 | Months 0 | Days 20 | If less than one day: hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fritz Grell
13. Birthplace Texas

MOTHER
14. Maiden Name Agnes Krentzlin
15. Birthplace Texas Texas

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery or crematory Wahoma
Location Baltimore Md

18 (a) Funeral director Tillson Funeral Home
(b) Address 2107 Pond St

JUN 22 1945 (Date rec'd by registrar)

(b) Huntington Williams Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14- 1945 to 6-15 1945, and that I last saw him alive on 6-15 1945.

Immediate cause of death: Coronary occlusion? Cerebral hemorrhage?

Duration: 4 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

37. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 6-19-45

VS 150

(OVER)

G30054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G30054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Yorkway (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Palmateer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertie M. Palmateer

6 (c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Oct 30 1893

8. AGE: Years 51 | Months 7 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace: Williamsport Pa (Town, county, and state)

10. Usual Occupation: Stock Clerk

11. Industry or business

FATHER
12. Name: Dont Know
13. Birthplace: " "

MOTHER
14. Maiden Name: Dont Know
15. Birthplace: " "

16 (a) Informant: Mrs Bertie Palmateer
(b) Address: 4188 Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22 (month) (day) (year)
(c) Cemetery or crematory: 1st United Evan. Cem. / All Saints Cem
Location: City

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2004 E Oldham St

19 JUN 22 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19- 1945, at 3:55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-19-45 at 1 A. M.
(b) Where did injury occur? Liberty Pkwy
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by street-car.

23. Signature: Robert A. Graham M.D. Medical Examiner.
Date signed 6-20-45

G30055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G30055

Registered No. .....

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Balto City Md.,
(a) Baltimore City, Maryland
(b) Street address 569 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 569 Baker St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary L Reed

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15th 1857

8. AGE: Years 88 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Hawkins
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Julia Crumpler
15. Birthplace Balto, Maryland

16 (a) Informant Jenny Reed
(b) Address 569 Baker St.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 6-22-45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Maryland

18 (a) Funeral director Litchfield & Geddes
(b) Address 210 W Fayette St

JUN 22 1945 Huntington Williams, Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1945

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945 to 6/20 1945 and that I last saw h[illegible] alive on 6/19 1945

Immediate cause of death Coronary Occlusion — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Burkhalter
Address 2/3 Dumas Apts (Date signed) 6/22/45 M. D.

G30056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G30056

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the te the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1121 Light Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1121 Light St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret K. Demitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife Charles F. Demitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1853

8. AGE: Years	Months	Days	If less than one day
92	4	22	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Ferdinand Frederick

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Ann —

15. Birthplace Germany

16 (a) Informant Elsie M. Demitz

(b) Address 1121 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Road

18 (a) Funeral director John F. Dennis, Inc.

(b) Address 715 Light Street

JUN 22 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1945 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1945 to 6/19 1945 and that I last saw he alive on 6/18 1945.

Immediate cause of death: Hypertensive cardio-vascular disease

Duration: —

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Weisel, M.D.

Address 1226 Hanover St Date signed 6/19/45

VS 150

G30057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G30057

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 N. MADERIA ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. MADERIA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER CISZEK (CHASE)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: CARRIE CISZEK

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) NOV. 3 1900

8. AGE: Years 44 | Months 7 | Days 17 | If less than one day: hr. min

9. Birthplace CHICAGO ILL. (Town, county, and state)

10. Usual Occupation PRODUCE DEALER

11. Industry or business FOR GLAESER

FATHER
12. Name GEORGE CISZEK
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant CARRIE CISZEK (WIFE)
(b) Address 2 N. MADERIA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 23/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zodarde
(b) Address 403 S. WOLFE ST.

19 (a) JUN 22 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS t50

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20 1945 at 4/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to June 20 1945, and that I last saw him alive on June 20 1945.

Immediate cause of death: Generalized Carcinomatosis — Duration: 1 mo.

Due to Carcinoma of stomach — 9 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb 6 1945

Major findings of operation: Carcinoma of stomach & metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 5007 E. Pratt St. Date signed 6/24/45

G30058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 51B

G30058 Registered No. 61776

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7352 Manchester Road, Dundalk
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Gorny, Antoni

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1889

8. AGE: Years	Months	Days	If less than one day
56		8	hr. min.

9. Birthplace Poland ?
(Town, county, and state)
10. Usual Occupation Poultryman
11. Industry or business

FATHER
12. Name Pete Gorny
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Frances Grochowski
(b) Address 7352 Manchester Rd.

17 (a) Burial (b) Date thereof June 22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto Co.

18 (a) Funeral director W. S. Fialkowski
(b) Address 2027 Eastern Ave

19 (a) JUN 22 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 45, at 9:05A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 19 45, to June 19 19 45, and that I last saw h im alive on June 19 19 45.

Immediate cause of death	Duration
Carcinoma of the prostate with multiple metastases to the pelvis, skull	
Due to and brain	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
Address U. S. Marine Hospit Date signed 6/20/45
Baltimore 11, Maryland.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G30059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G30059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 79 S. Kossuth St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 79 S. Kossuth St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Catherine B. Baldwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Howard W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1872

8. AGE: Years 72 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace — (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm A. O'Donnell
13. Birthplace Ireland

MOTHER
14. Maiden Name — Lowe
15. Birthplace Md.

16 (a) Informant Howard W. Baldwin
(b) Address 79 S. Kossuth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) JUN 22 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to June 20 1945 and that I last saw h-er alive on June 20 1945.

Immediate cause of death: Broncho-Pneumonia — Duration: 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry A. Yates

Address 517 Scott St. Date signed 6/21/45 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30060 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Reisterstown Road
(c) Hospital or institution:

15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Abel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Aaron Katz
13. Birthplace Russia

MOTHER
14. Maiden Name Esther ?
15. Birthplace Russia

16 (a) Informant Isaac Abel
(b) Address 3519 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Rosedale Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 JUN 22 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

10.05

20. DATE OF DEATH June 21 1945 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1930, to June 20 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
arterio-sclerosis	12 yrs
Due to diabetes mellitus	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address 1725 Eutaw Pl Date signed 6/22/45 M. D.

VS 150

G30061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30061

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland N.W.C.

(b) Street address St. Paul and 31st. Sts.

(c) Hospital or institution Hopkins 12-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ----------

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. St. Paul and 31st. Sts. (If rural give location)

(e) Citizen of foreign country? ---------- (Yes or No)

If yes, name country ----------

3 (a) FULL NAME Michael J. Lindsay

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----------

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	25	--- hr. --- min.

9. Birthplace Texas. Balto. Co. . Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business ----------

FATHER

12. Name Hugh Lindsay

13. Birthplace Ireland

MOTHER

14. Maiden Name Catherine Buckley

15. Birthplace Ireland

16 (a) Informant Miss Ella Lindsay

(b) Address Hopkins Apt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)

(c) Cemetery ####### St. Joseph's

Location Texas. Balto. Co., Md.

18 (a) Funeral director H. H. Mears and Son

(b) Address 805 N. Calvert St.

19 JUN 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to June 20 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Hypertensive Vascular Disease Cerebral Hemorrhage	2 Days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thos. C. Goldsborough M. D.

Address 2420 St Paul St Date signed 6/22/45

G30062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30062 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 E. Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Roman
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband/wife Maryanna Roman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1887

8. AGE: Years 58 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Paul Roman
13. Birthplace Poland

MOTHER
14. Maiden Name Rogalski
15. Birthplace Poland

16. (a) Informant Maryanna Roman
(b) Address 2616 E Baltimore St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Orazewski
(b) Address 1930 Eastern Ave
JUN 22 1945 (Date received by local registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1945, to June 21 1945 and that I last saw him alive on June 21 1945.

Immediate cause of death	Duration
HYPERTENSIVE CARDIO-VASCULAR DISEASE	1/26/45
Due to	
Due to	
Other Conditions CEREBRAL HEMORRHAGE	1933

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. F. Maenza M. D.
Address 2000 Chester St Date signed 6/22/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

630063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 630063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kunegunda Rakowski (Roek)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Rakowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/45

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Joseph Schultz
13. Birthplace Poland

MOTHER
14. Maiden Name Francis Lubawski
15. Birthplace Poland

16 (a) Informant Joseph Rakowski
(b) Address 2917 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Krazewski
(b) Address 1930 Eastern Ave

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

JUN 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 2:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1944, to June 20 1945, and that I last saw h Et alive on June 20 1945.

Immediate cause of death: TERMINAL BRONCHO-PNEUMONIA — Duration 6/19/45

Due to ARTERIOSCLEROTIC, HYPERTENSIVE CARDIO-VASCULAR DISEASE — Duration MARCH 1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Krauza M. D.

Address 2017 E. Chester St Date signed 6/22/45

X

G30064

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30064
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto, Md.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 University Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Spidel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1889

8. AGE: Years	Months	Days	If less than one day
56	5	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Springer
15. Birthplace Maryland

16 (a) Informant Mrs. Mae Mannel
(b) Address 1521 Cole Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director George A. Starling
(b) Address Fallsway & Fayette

19 (a) (b) Huntington Williams, M.D.
Registrar

JUN 22 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1945, at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Subacute Bacterial Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard S. Mueller, M.D.
Medical Examiner.
Date signed 6-21-45

G30065

AB-94249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12B

G30065 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Ross

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7- 1927

8. AGE: Years	Months	Days	If less than one day
18	0	12	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nathaniel Ross
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Lee
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6 22 45
(month) (day) (year)
(c) Cemetery or crematory Mt. Calary
Location Baltimore

18 (a) Funeral director Walter B. Spruggs
(b) Address 139 W. Hamburg St. Hunting Town Williams, Md

19 (a) JUN 22 1945 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19- 1945, at 9.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18- 1945, to 6-19 1945, and that I last saw her alive on 6-19 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	(?)
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions Intestinal Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: confirmatory.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 6/20/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30066 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2308 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDGAR WIEST

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214 - 01 - 5067

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian L. Wiest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1886

8. AGE: Years 59 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business American Ice Co.

FATHER
12. Name William A. Wiest
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Nellie Read
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary R. Faustman
(b) Address 2308 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 20, 1945, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 45, to June 20 19 45, and that I last saw h[illegible] alive on June 20 19 45.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions: Obesity.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Wiest M. D.

Address 1314-20 North Av. Date signed 6/21/45

G300637

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G300637

CERTIFICATE OF DEATH 82a

Reg. Dist. No.

1. PLACE OF DEATH:

County —

City or town Baltimore (15)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 3308 Devonshire Drive

Stay in hospital or inst. (yrs., or mos., or days) not any

Stay in this community (yrs., or mos., or days) 69 yrs. formerly; lately 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County —

City or town Baltimore (15) Ward No. 37th
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3308 Devonshire Drive
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME FLORA RENATA FRAZER

3. (b) Social Security Number none.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John F. Frazer Sr.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jany 17 1863

8. AGE: Years	Months	Days	If less than one day
82	5	4	hrs. min.

9. Birthplace Berlin Germany
(Town, county, and state)

10. Usual occupation Housekeeping

11. Industry or business

FATHER 12. Name John Kaas

13. Birthplace Germany

MOTHER 14. Maiden name Henrietta Schewe

15. Birthplace Germany

16. Informant John F. Frazer, Jr.

Address 3308 Devonshire Drive, Baltimore 15, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/24/45
(month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Gettysburg, Penna.

18. Funeral director D. Milton Bender

Address Gettysburg, Pa.

JUN 22 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1945, to June 21 1945, and that I last saw h alive on June 21 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5/26/45
Due to	
Due to	
-	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. D. Seibert M. D. or Coroner

Address 4803 Park Heights Ave Date signed 6/22/45

IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G30068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Chestnut Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Chestnut Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE A. BEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Edna P. Beyer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 26, 1892

8. AGE: Years	Months	Days	If less than one day
52	6	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Driver
11. Industry or business

FATHER
12. Name Michael Beyer
13. Birthplace Balto.

MOTHER
14. Maiden Name Augusta Pranke
15. Birthplace Balto.

16 (a) Informant Miss Anna E. Beyer
(b) Address 902 Chestnut Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) JUN 22 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 21, 1945, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1-45 to 6-21-45; and that I last saw him alive on 6/19/45.

Immediate cause of death Carcinoma Larynx — Duration 6 mo
Due to
Due to
Other Conditions Bronchopneumonia — 4 days
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. W. Herrmann M.D.
Address 1710 E. 33rd Date signed 6/22/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G30069
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Theresa Di Maio

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marco Di Maio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 8 1883

8. AGE: Years: 62 | Months: 5 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business: home

FATHER
12. Name: Guido Rivelo
13. Birthplace: Italy

MOTHER
14. Maiden Name: Maria Giovanna ?
15. Birthplace: Italy

16 (a) Informant: Andy Di Maio (Son)
(b) Address: 4211 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25 1945 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Fraull Della Noce
(b) Address: 52 N. Morley St.

JUN 22 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16, 1945, to June 21, 1945, and that I last saw her alive on June 20, 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 week
Due to Arteriosclerosis	Unknown
Myocarditis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Christiano Artigiani M. D.
Address 2942 E. Fayette St. Date signed 6/22/45

G30070

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G30070

CERTIFICATE OF DEATH 72B

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Millers (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Jacob H. Zepp
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1870

8. AGE: Years	Months	Days	If less than one day
74 75	8	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Ira Barney Zepp
13. Birthplace Carroll Co, Md

MOTHER
14. Maiden Name Katherine Mathias
15. Birthplace Carroll Co, Md

16 (a) Informant Mrs. Michael Leister
(b) Address Millers, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1/45 (month) (day) (year)
(c) Cemetery or crematory Hanover
Location Pa.

18 (a) Funeral director Jacob Winkelmans
(b) Address Manchester, Md

19 (a) (b)
(Signature of local registrar) (Date received) (Registrar)

JUN 22 1945

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1945 at 8 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1945, to 6/20 1945, and that I last saw him alive on 6/20 1945.

Immediate cause of death	Duration
Anemia	
Due to Hemorrhage (spont.) into L. Knee joint	
Due to Probable hemorrhagic diathesis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Harold M. D.
Address Md. Gen. Hosp. Date signed 6/22/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color, age is especially important. Physicians: please write the causes of death clearly and legibly.

G30071 Lewis ✓ G30071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 502 Vincent Ave

(c) ~~Hospital or institution~~ Balto, Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 502 Vincent (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Laure Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband William Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1880

8. AGE: Years 65 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Howard Co. Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Robert Cure

13. Birthplace Howard Co., Md.

MOTHER

14. Maiden Name Hannah Holland

15. Birthplace Prince George Co.

16 (a) Informant Lillian Cure Henson

(b) Address 502 Vincent.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-'46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Wallinger

(b) Address 322 N Schroeder St

JUN 22 1945

(Date rec'd by registrar) Huntington Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945, to 6/17 1945, and that I last saw h alive on 6/17 1945.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. Welcome M. D.

Address 1131 Harlem Date signed 6/22/45

G30072 ✓X G30072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min
(e) Length of stay in Baltimore (yrs., mos., or days) 25 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fullerton Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Stephens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 25 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Stapleton
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Maria Bialek
15. Birthplace Baltimore Md

16 (a) Informant Maria Stapleton
(b) Address Fullerton Md.

17 (a) Burial (b) Date thereof 6 23 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto Md

18 (a) Funeral director George A. Farley
(b) Address Fayette & Fulton Ave

19 (a) 6-22-1945 (b) Huntington Williams M.D.
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21 1945 at 9 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1945 to 6-21 1945 and that I last saw h[illegible] alive on 6-21 1945

Immediate cause of death: Cardio-Resp. Failure

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Inglis M. D.

Address Mercy Hosp. Date signed 6/21/45

X

G30073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G30073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md General Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1880

8. AGE: Years	Months	Days	If less than one day
Abt. 65			hr. min.

9. Birthplace Finland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Samuel Jackson
13. Birthplace Finland

MOTHER
14. Maiden Name Nokagom
15. Birthplace Finland

16 (a) Informant L B Smith
(b) Address Pittsburgh Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/22/45 (month) (day) (year)
(c) Cemetery or crematory United Cem
Location Pittsburgh Pa

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) JUN 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 9 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Ant. Ruptured Spleen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 21 1945 8 45 A.M.
(b) Where did injury occur? 2101 Callow Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home Indus While at work? Yes
(d) Means of injury Fall from scaffold

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 21 1945

VS 151

G30074 Josepha

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G30074

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2 N. Rose st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 24 N. Rose st (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine (Josepha) Jirsa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph Jirsa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1871

8. AGE: Years	Months	Days	If less than one day hr.	min.
74		24		

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Joseph Juda

13. Birthplace Bohemia

MOTHER

14. Maiden Name Not known

15. Birthplace Bohemia

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md.

18 (a) Funeral director Frank Brack & Son

(b) Address 900 N. Chester st

19 (a) Date received by local registrar JUN 22 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945; about 11.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945, to June 20 1945, and that I last saw h[illegible] alive on June 20 1945

Immediate cause of death Congestive Failure

Due to Coronary Sclerosis

Due to General Arterio-sclerosis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

Congestive Failure ?

Coronary Sclerosis ?

General Arterio-sclerosis ?

Hypertension ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)

(e) Means of injury —

23. Signature Thomas H. Sparks M.D.

Address 845 Cathedral St Date signed 6/22/45

G30075 CRUMBIE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G30075 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 84 W Main St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Crumbie

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John C. Crumbie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1896

8. AGE: Years 48 49 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation Home keeper

11. Industry or business —

FATHER 12. Name William Hamm

13. Birthplace West minster, Md

MOTHER 14. Maiden Name Mary Miller

15. Birthplace Harpers Ferry

16 (a) Informant Retired

(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-45 (month) (day) (year)

(c) Cemetery or crematory Westminster Cem

Location Westminster, Md.

18 (a) Funeral director Francis Reese

(b) Address Westminster, Md.

JUN 22 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 8 35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945, to June 21, 1945, and that I last saw her alive on June 21, 1945.

Immediate cause of death	Duration
Immediate	
Due to Carcinoma of liver? with metastasis	
Due to	
Other Conditions Cholecystitis, cholelith	

(Include pregnancy within 3 months of death)

Date of operation June 5, 1945

Major findings of operation: Carcinoma in liver? Cholecystitis, Cholelithiasis

of autopsy: Carcinoma of liver?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Steven Hatch M. D.

Address C.H.H. Date signed 6-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G30076 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 365 Potomac
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 365 Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Wietscher

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Mary Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22nd 78

8. AGE: Years 67 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Casket Co.

FATHER
12. Name W. Albert Wietscher
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Greb
15. Birthplace Germany

16 (a) Informant Sophia Brautigam
(b) Address 365 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 20 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

JUN 22 1945 (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22nd 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19 Not attending Physician recently. H.J.M.

Immediate cause of death Cardio Dilatation & Mr Heart — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh A. Sadler M. D.

Address 3173 E. Baltimore Date signed 6/23/45

VS 150

For Dr. Joseph Sherbow, by Thomas J. Watkins, M.D.

G30077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30077

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 S. Decker Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 S. Decker Aveme
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: MICHAEL WIERUSZEWSKI

3 (b) If veteran, name war: ***

3 (c) Social Security Account No. 216-24-1797

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/65

8. AGE: Years 79 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Poznan, Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ------ Wieruszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Rose Gasior
(b) Address 630 S. Decker Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) (Date rec'd by registrar) 6 22 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1945 at 6 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944 to June 20 1945 and that I last saw h[illegible] alive on June 18 1945.

Immediate cause of death Cerebral apoplexy

Due to Chronic Hypertension

Due to

Other Conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: day, several months, several months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J. Kroger M. D.

Address 627 Rosedale Date signed

G30078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1942 64c

G30078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Malster ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen Meyers

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Oct 24-1911

8. AGE: Years	Months	Days	If less than one day
33	7	25	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Philip Meyers.
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Catherine Hunterlay.
15. Birthplace Wisconsin

16 (a) Informant Mrs Winifred Casey.
(b) Address 1508 Malster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-42 (month) (day) (year)
(c) Cemetery or crematory Baltimore Metard
Location Fred Rd Ext

18 (a) Funeral director G. Lee Adel
(b) Address 4644 York Rd.

JUN 22 1942 (Date rec'd by registrar) (b) Huntington Williams Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19- 1942, at 1-15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-19- at 12 Noon
(b) Where did injury occur? 1508 Malster ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - automatic pistol.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 6-20-42

G30079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30079 (MA)

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 678 W. Fairmount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 678 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter (Farrell) FARRER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married FARRER

6 (b) Name of husband or wife Hester (Farrell)

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec - 24-1895

8. AGE: Years 49 | Months 50 | Days 5 | If less than one day ..... hr. ..... min. 26

9. Birthplace Catawba Co N. C. (Town, county, and state)

10. Usual Occupation Tracer

11. Industry or business

FATHER
12. Name Charles (Farrell) FARRER
13. Birthplace Lincoln Co - N C

MOTHER
14. Maiden Name Laura Staton
15. Birthplace Gaston Co - N. C.

16 (a) Informant Hester (Farrell) FARRER
(b) Address 678 W Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-45 (month) (day) (year)
(c) Cemetery or crematory Shipp's
Location Catawba N. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
JUN 22 1945 Huntington Williams, MD
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 19 1945, at 11 10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov - 10 1943 to June 19 1945, and that I last saw h[illegible] alive on June 18 1945.

Immediate cause of death Uraemia
as a result of
Due to Hypertension
Due to Hemiplegia
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Crawford M. D.
Address 22 W Lee St Date signed 6/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 309

Registered No. G30030

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 N Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 N Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A Foster

3 (b) If veteran, name war: WW
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah E Foster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1877

8. AGE: Years 67 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business Owner

FATHER
12. Name Samuel Henry Foster
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Estelle Kane
15. Birthplace Baltimore, Md

16 (a) Informant Sarah E Foster
(b) Address 1109 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 23 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Watson Funeral Home
(b) Address 247 W Lanvale St

19 JUN 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at M

21. I certify that death occurred on the date above-stated; that I attended deceased from May 14 19, to 6/20 19, and that I last saw h[im] alive on 6/20 19 45.

Immediate cause of death

	Duration, Min. Hrs. Days
Due to Acute Fulminating Lobar Pneumonia	FUL
Due to	
Other Conditions Syphilis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury H. H. Houston

23. Signature 733 Augusta Ave
Address Date signed 6/23/45

108

G30081

S-25101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G30081

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: University Hosp 21

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 810 Conway St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby Boy Henry.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1945

8. AGE: Years | Months | Days 14 | If less than one day hr. min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation .....

11. Industry or business —

FATHER

12. Name Keiffus Henry Sr.

13. Birthplace Russell Co. Alabama

MOTHER

14. Maiden Name Veronica Baxter

15. Birthplace North Carolina

16 (a) Informant Hosp Records

(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory .....

Location UNIVERSITY MEDICAL SCHOOL JUN 6 1945

18 (a) Funeral director Commissioner of Health

(b) Address .....

19 JUN 23 1945 (Date rec'd by registrar) Humbert to Williams MR (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945, to June 5 1945, and that I last saw h[illegible] alive on June 5 1945

Immediate cause of death	Duration
Intracranial Hemorrhage, birth	
Due to Spontaneously	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature J Curich MD M. D.

Address University Hosp Date signed 6-5-45

VS 150

F2776

X

G30032 ✓ G30032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 111C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Melvin Thomas Boykin

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1945

8. AGE: Years	Months	Days	If less than one day
	5	19	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Charles Lee Boykin
13. Birthplace North Carolina

MOTHER
14. Maiden Name Vivian Harris
15. Birthplace Portsmouth, Va.

16 (a) Informant Charles Lee Boykin
(b) Address 1719 W. Lanvale st

17 (a) Burial (b) Date thereof 6/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Landsdowne Md.

18 (a) Funeral director Chas H Abernathy
(b) Address 927 N. Mount St.

19 JUN 23 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1945, at 10:30 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 22 1945

G30083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G30083
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Providence St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days) 27-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Providence St (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Helen George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25. 1887

8. AGE: Years	Months	Days	If less than one day
57 58	6	25	hr. min.

9. Birthplace Essex Co. Va (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Lewis George
13. Birthplace Va

MOTHER
14. Maiden Name Phoeba Sturman
15. Birthplace Va

16 (a) Informant Helena G. George
(b) Address 1011 Providence St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location

18 (a) Funeral director James A. Hayes
(b) Address 1242 W. Fayette St

19 (a) JUN 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 11:12 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 20 1945, and that I last saw him alive on 6-20 1945.

Immediate cause of death	Duration
(a) Hypertensive Cardiac Disease	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1536 W. Fayette St. Date signed 6-22-45

G30034 G30034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 909 N Dris St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 909 N Dris St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Jennie Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Geo W. Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 15 1861

8. AGE: Years 84 Months 81 Days 3 If less than one day hr. 76 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Michael

13. Birthplace Germany

MOTHER 14. Maiden Name Don't Know

15. Birthplace Germany

16 (a) Informant Sister Louise P. Koch

(b) Address 909 N Dris St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) JUN 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 20 1945 to June 21 1945, and that I last saw her alive on June 21 1945.

Immediate cause of death Carcinoma of Lung — Duration 6 Mos.

Due to

Due to

Other Conditions Arterio-sclerotic Hypertensive Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Fiedler M. D.

Address 1101 E. Fayette St Date signed 6/27/45

G30035 Lacher

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30035

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. Hoffman St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Sachen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Sachen

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 13, 1881

8. AGE: Years 64 | Months — | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Dont Know
13. Birthplace

MOTHER
14. Maiden Name: Emma Pistel
15. Birthplace: Baltimore

16 (a) Informant: Lidrais Bentley
(b) Address: 1541 N. C. P. K Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 25th (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 200 S Arlington St

19 (a) JUN 23 1945 (Date rec'd by registrar) Huntington Williams, Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21- 1945; at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 6-22-45

VS 151

G30036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G30036

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo. 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Copley Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frances Elizabeth Benson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Rev. Frank T. Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1858

8. AGE:	Years	Months	Days	If less than one day
	87	1	13	hr. min.

9. Birthplace Liberty Town, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joshua Thomas Murray
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary A. C. D. H. Emory
15. Birthplace Queen Annes County, Md.

16 (a) Informant Mount Hope Retreat
(b) Address 6425 Reisterstown Rd. Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Location David Ridge Cem. Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Bro.
(b) Address 1900 Eutaw Place

19 Date received JUN 23 1945 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945 at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 9 1945 to June 22 1945, and that I last saw h e alive on June 22 1945.

Immediate cause of death: Cardio vascular collapse — Duration: 1 week

Due to

Due to

Other Conditions Psychosis with arteriosclerosis — Duration: 5 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. T. Magee M. D.

Address 336 Cathedral St. Date signed

G30087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G30087

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Severna Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Old County Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edwin Rife

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ wife Sue Pennington Rife
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 4-5-91

8. AGE: Years	Months	Days	If less than one day
54	2	16	..... hr. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Machinery manufacturer
11. Industry or business

FATHER
12. Name William H. Rife
13. Birthplace Ohio

MOTHER
14. Maiden Name Jennie McCullough
15. Birthplace Ohio

16 (a) Informant Hospital chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons Co.
(b) Address 1900 Eutaw Place

19 (a) JUN 23 1946 (Date received by registrar) Huntington Willis M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21 1945, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 1945 to 6-21 1945, and that I last saw him alive on 6-21 1945.

Immediate cause of death Cardio-Respiratory Failure — Duration .....

Due to Acute myelogenous leukemia — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Alfred C. Hutchinson M. D.
Address 208 E. 34th St Date signed 6-21-45

VS 150

G30088

JO #94010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30086 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** August Moog

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife ? ? ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1860

8. AGE: Years	Months	Days	If less than one day
85	3	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation On Pension
11. Industry or business

FATHER
12. Name Herman Moog
13. Birthplace Berlin, Germany

MOTHER
14. Maiden Name Wilhemina Zimmerman
15. Birthplace Berlin, Germany

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location

18 (a) Funeral director C. Vernon Zeman
(b) Address 4611 Pk. Heights
Huntington Williams M.P.

JUN 23 1945 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1945, at 1:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4, 1945, to June 21, 1945, and that I last saw him alive on June 20, 1945.

Immediate cause of death	Duration
Congestive heart failure	?
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions Cerebral Arteriosclerosis.	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. M. Shurlight M.D.
Address Balto City Hosp Date signed 6-23-45

VS 150

G30039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30039 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) City of Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 858 W. 37th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Lee Childs
3 (b) If veteran, name war Ford #1
3 (c) Social Security Account No. —
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name ~~of husband~~ or wife Myrtle Alma Childs
6 (c) If alive, give age ~~—~~ years
7. Birth date of deceased (mo., day, yr.) 12-27-91
8. AGE: Years 53 Months 5 Days 25 If less than one day ____ hr. ____ min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Post Office Clerk
11. Industry or business
FATHER 12. Name Frank Childs
13. Birthplace Maryland
MOTHER 14. Maiden Name Hester Peregoy
15. Birthplace Maryland
16 (a) Informant Hospital Chart
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 4231 Falls Road Huntington Avenue, Md.
19 (a) JUN 23 1945 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1945, at 12:55A M
21. I certify that death occurred on the date above stated; that I attended deceased from ~~the~~ 6/20 1945, to 6/22 1945, and that I last saw him alive on 6/22 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Uremia	
Due to Coronary thrombosis Embolism	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo. W. Waterman Jr. M. D.
Address 332 E. Lanvale St. Baltimore. Date signed 6/22/45

VS 150

G30030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G30030 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3431 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman N. Grimm

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-8316

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Calder Grimm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1880

8. AGE: Years 65 | Months — | Days 17 | If less than one day hr. min.

9. Birthplace Harford Co. Maryland
(Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business Pennsylvania Railroad

FATHER
12. Name George Washington Grimm
13. Birthplace York, Pennsylvania

MOTHER
14. Maiden Name Matilda J. Hudson
15. Birthplace Maryland

16 (a) Informant Mrs. E. Calder Grimm
(b) Address 3431 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23-1945 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore Co., Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JUN 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Fractured ribs

Due to Fracture Pelvis

Internal hemorrhage

Other Conditions Laceration of kidney

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury June 20, 1945 3:20 P.M.

(b) Where did injury occur? Newkirk & East Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Railroad While at work? Yes

(d) Means of injury Struck by train

23. Signature Howard J. McCleary M.D.
Medical Examiner.

Date signed 6-21-45

G30091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30091

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Dunkirk Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Seth Duff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Florence Duff

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/24/1874

8. AGE: Years 71 | Months 2 | Days 28 | If less than one day hr. ..... min. .....

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Henry Duff
13. Birthplace Md

MOTHER
14. Maiden Name Jennie Fitzpatrick
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Harry A. Welsh
(b) Address 4101 E. Monument Ave

19 (a) Interment (b) Undertaker Huntington Williams

JUN 23 1945

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1945 at 10 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1945 to 6/22 1945, and that I last saw h i m alive on 6/22 1945.

Immediate cause of death Resp. Failure — Duration .....

Due to Coronary Thrombosis — Duration 17 days

Due to ..... — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Earl K. Bateman M.D. M. D.

Address Mercy Hosp. Date signed 6/23/45

G30092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 520

G30092

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2107 No Henry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2107 No Henry St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles H. Briel

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-8298

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Verna E. Briel

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) July 31st 1900

8. AGE: Years 44 | Months 10 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Mgr Retail Appliance

11. Industry or business Gas Bottle Co

FATHER

12. Name Lehr Briel

13. Birthplace Md

MOTHER

14. Maiden Name Julia Kirkwood

15. Birthplace Md

16 (a) Informant Verna E. Briel

(b) Address 2107 No. Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md

18 (a) Funeral director F. A. Hepfer Son

(b) Address 1300 Eutaw Place

19 (a) JUN 23 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21st 1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to June 21 1945 and that I last saw h. m. alive on June 21 1945.

	Duration
Immediate cause of death: Squamous cell Carcinoma of Bladder	20 Mos.
Due to:	
Due to:	
Other Conditions: Carcinoma to bone & skull (Include pregnancy within 3 months of death)	8 Mos.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. Palagia M. D.

Address 336 Eutaw St Date signed 6/24/45

G30093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G30093 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Fifth St
(c) Hospital or institution St Agnes Hospt 25 E Lex
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Fifth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna M Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife R. W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-1889

8. AGE: Years	Months	Days	If less than one day
56	4	20	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph F Meyer
13. Birthplace Md

MOTHER
14. Maiden Name Anna Schmidt
15. Birthplace Germany

16 (a) Informant R W
(b) Address 3809 Fifth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Rubert Elliott & Fowlson

18 (a) Funeral director
(b) Address 2309 Pennsylvania Ave

19 JUN 23 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945; at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 30 1945 to June 21 1945 and that I last saw h-er alive on June 21 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 5 hrs
Due to Essential Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Novak M. D.
Address 101 W. Read St Date signed 6-27-45

VS 150

Must have this certificate approved

30094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 124 B

G30094

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 822 S. Milton ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 822 S. Milton ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adam Platerzyk (Wadrich)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1877

8. **AGE:** Years 68 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Poland

MOTHER

14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mrs Victoria Platerzyk

(b) Address 822 S. Milton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 26 45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore Cemetery

18 (a) Funeral director 491 S. Chester Street

(b) Address John M. Weber

19 (a) (Date rec'd) JUN 23 1945 (b) Huntington Williams, M.D. (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1945 to June 22 1945, and that I last saw him alive on June 21 1945.

Immediate cause of death	Duration
Coronary Thrombosis	6/20/45
Due to Chr. Myocarditis	1/1945
Due to Cirrhosis of Liver	1/1943
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature William J. Dyaver M. D.

Address 8011 Belmont ave Date signed 6/27/45

Approved by Howard J. Mendis, M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G30095

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 E. Eager St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 E. Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William H. Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-04-9779

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1891

8. AGE: Years	Months	Days	If less than one day
53	9	5	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Edward Gibson
13. Birthplace Canada

MOTHER
14. Maiden Name Mary Sumgerville
15. Birthplace Balto Md

16 (a) Informant Marie Gibson
(b) Address 1614 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location E. L. County, Md

18 (a) Funeral director Joseph G. Locke, Jr.
(b) Address 1306 N. Central Ave

19 JUN 23 1945 (Date rec'd by registrar) Huntington Williams Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1945 at 7 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1945 to 6-21 1945 and that I last saw h— alive on 6-21 1945

Immediate cause of death Acute myocarditis — Duration 2 hours

Due to Heat prostration — Duration 4 hours

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Lee Lowe M. D.
Address 1420 E. Chase Date signed 6-23-45

VS 150

G300936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. G300936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 N. Calvin Street
(If rural give location)
(e) Citizen of foreign country? Returned (Yes or No)
If yes, name country .....

3 (a) FULL NAME Benjamin Benson

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced. Divorced
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1900

8. AGE: Years 45 | Months 4 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Tovana Maryland
(Town, county, and state)

10. Usual Occupation Lumber
11. Industry or business .....

FATHER
12. Name Mathews Benson
13. Birthplace Maryland

MOTHER
14. Maiden Name Nellie Harris
15. Birthplace Maryland

16 (a) Informant Mrs. Rachel Barnes
(b) Address 104 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Lok, Jr.
(b) Address 1430 N. Central Ave

19 (a) JUN 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 21, 1945, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Due to .....
Other Condition Pneumonia (Myocardial), Lobar Pneumonia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed June 21, 1945

G30037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30037 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly ... The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Fawney Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29 1882

8. AGE:

Years	Months	Days	If less than one day
63	4	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Rawlings.
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Georgiana
15. Birthplace Calvert Co. Md.

16 (a) Informant Mabel Cook.
(b) Address 751 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 JUN 23 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION - 3:05

20. DATE OF DEATH June 19, 45 19 , at P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 20 1945

G30098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45B

G30098
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Alice Anna St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Martin Norwood.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-72

8. AGE: Years 73 | Months - | Days 26 | If less than one day: hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Norwood
13. Birthplace " "

MOTHER
14. Maiden Name Mary Coldwell
15. Birthplace " "

16 (a) Informant Reconda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location 5 North ave

18 (a) Funeral director Clarence F. Hoffman
(b) Address 639 N Broadway

19. JUN 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 5.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1945, to June 22 1945, and that I last saw him alive on June 22 1945.

Immediate cause of death: Shock from massive Retal Hemorrhage — Duration

Due to ???

Other Conditions: Gangrene of Prepuce with Calculus

2 surgical Mutilations, atherosclerosis of Aorta & Mitral insufficiency

Operation: Circumcision — Date of operation: March 20

(Include pregnancy within 3 months of death)

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Graham A. Vence, M.D.
Address Johns Hopkins Date signed 6/22

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C30099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C30099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Fred Hoffman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 4 1850

8. AGE: Years	Months	Days	If less than one day
94	7	17	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Family
(b) Address 1936 Hollins

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Md

18 (a) Funeral director Thos. F. Keeney
(b) Address Hollidaysburg Huntington Williamsport Pa

JUN 23 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 8 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to June 21 1945, and that I last saw her alive on June 16 1945.

Immediate cause of death	Duration
Pneumonia. Hypostatic	7 days
Due to Myocardial degeneration	7
Due to Arterio Sclerosis, Gen.	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel E. Bogorad, Jun. M. D.
Address 1905 W. Balto. Date signed 6/22/45

VS 150

630100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 630100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 Arunah Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Arunah Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Chagouris CHAGOURIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Stella Chagouris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Stella Chagouris
(b) Address 2913 Arunah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-45 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem.
Location Baltimore Md.

18 (a) Funeral director Sherwood & Leaington
(b) Address 21 W. 25th St.

19 (a) JUN 23 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to June 21 1945
and that I last saw h alive on June 10 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to arteriosclerosis	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Novak M. D.
Address 101 W. Read St. Date signed 6-25-45

VS 150

G30101 — BALTIMORE CITY HEALTH DEPARTMENT — G30101

CERTIFICATE OF DEATH 45 B

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 E. North Ave
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William B. Flynn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months - | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation PENN. R.R. DISPATCHER.

11. Industry or business

FATHER 12. Name Patrick Flynn
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget McNicholas
15. Birthplace Ireland

16 (a) Informant Mrs Paul Flynn
(b) Address 527 E. 32nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Friedefeld
(b) Address 501 E. 32nd St.

19 (a) (Registrar) (b) JUN 24 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 10 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 21 1945, and that I last saw him alive on June 21 1945.

Immediate cause of death: Carcinoma of tongue — Duration 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Frenyear M.D.
Address 1402 E. Lanvale St. Date signed 6-23-45

X

G30102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30102 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 E Montgomery St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Bower

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant David Bower
(b) Address 3506 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Blvd
Location Washington Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) [illegible] Huntington Williams, M.D. (Date received by registrar) Registrar
JUN 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1945, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945, to 6/21 1945 and that I last saw her alive on 6/21 1945.

Immediate cause of death: Acute Cardiac dilatation

Due to: Ch myocarditis

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ada Hometen M. D.
Address 733 Argonne St Date signed 6/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30103 — BALTIMORE CITY HEALTH DEPARTMENT — G30103

CERTIFICATE OF DEATH

Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere + Greenspring
(c) Hospital or institution: Helen Home for Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Golfie Weemtein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dairy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 64 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Benj. Weemtein
(b) Address 5401 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-45 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location O Donnel St

18 (a) Funeral director Jack Lenz Inc
(b) Address 1439 E. Baltimore St

19 (a) [illegible] (Local registrar) Huntington Williams M.D. Registrar

JUN 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 11.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1941, to 6-22 1945, and that I last saw h[illegible] alive on 6-22 1945.

Immediate cause of death	Duration
Cerebral haemorrhage	
Parkinsons Syndrome	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Lewin

Address Lutherville Date signed 6/26/45

VS 150

G30104 BALTIMORE CITY HEALTH DEPARTMENT Zender ✓ G30104

CERTIFICATE OF DEATH 52B

Registered No. 1

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Parkside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Magaret Zender
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Phila. Pa (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Rubin Meisel
13. Birthplace Russia

MOTHER 14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St. Huntington Williams, Pa.
19 (a) (Date rec'd by registrar) Registrar

JUN 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1945, at 10:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1945 to 6/22 1945, and that I last saw h er alive on 6/22 1945.

Immediate cause of death

Duration

Due to Hem. into Peritneal Cavity

Due to

Other Conditions Ca. of Bladder

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hem. in Peritneal Cavity, Rt Ht Ureter - Bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip H. Lerman
Address Sinai Hospital Date signed 6/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30105

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G30105 83B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hosp
(c) Hospital or institution 33rd & Calvert Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 N. Pulaski St.
(If non-numbered give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. [redacted] Sacks (Jennie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 56 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edel Sacks
13. Birthplace Russia

MOTHER
14. Maiden Name Reva Leah
15. Birthplace Russia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Old Rd. & Hamilton Ave

18 (a) Funeral director Jack Levy Funeral
(b) Address 1439 E. Baltimore St

19 (a) (b) Pennington Williams, M.D.
(Date received by registrar) JUN 24 1945 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945, to June 22 1945, and that I last saw h. alive on June 22 1945.

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Cerebral Thrombosis	
Due to Generalized Arterio-Sclerosis	
Other Conditions Chronic Parkinsonism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Spragins M. D.
Address U. M. H. Date signed 6-22-45

USE 150

X

G30:06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30:06
Registered No.

JO #94269

131a

—MARGIN RESERVED FOR BINDING—PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 W. 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EVelyn Mae Triplett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1914

8. AGE: Years	Months	Days	If less than one day
30	9	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hugh Triplett
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ridgley
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodstock
Location Granite, Md

18 (a) Funeral director Ehrenwerth & Sonnen
(b) Address 3415-17 Chestnut Ave.

19 (a) (Date received by registrar) (b) Registrar

JUN 24 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH June 21, 1945, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19, 1945, to June 21, 1945, and that I last saw her alive on June 21, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage ?	1 hr
Due to Hypertensive Heart disease	?
Due to	
Other Conditions Nephrosclerosis anemia	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 6-23-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30107 — BALTIMORE CITY HEALTH DEPARTMENT — G30107

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 N. Loudon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 N. Loudon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susan Virginia McKnight

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John McKnight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1852

8. AGE: Years 93 Months 2. Days If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Evans
13. Birthplace Md.

MOTHER
14. Maiden Name Esther Aydelotte
15. Birthplace Md.

16 (a) Informant Miss Esther D. Bell
(b) Address 2902

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6-25-45 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Loudenmount
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Local Registrar) (b) Registered JUN 24 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945, to June 22 1945, and that I last saw her alive on June 21 1945.

Immediate cause of death — Duration

Cardiac failure

Due to Generalized arteriosclerosis

Due to

Other Conditions Malignancy Breast

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Thorsby M.D.

Address 601 N. Monroe St. Date signed 6/22/45 M. D.

97

G30108
AB-93738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30108 / 1147

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-1day
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Richard Stehr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27-1886

8. AGE: Years	Months	Days	If less than one day
59	2	25	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Stehr (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schultz (D)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Paul Cem
Location Loudiffton
18 (a) Funeral director John F. Hagan
(b) Address 3000 E. Balto St.
19 (a) Huntington Williams, M.D. (Signature of person who rec'd by registrar) Registrar

JUN 24 1945
VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER Stamped X Robert Lee Graham M.D. 6/24/45

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1945, to 6-22 1945, and that I last saw him alive on 6-22- 1945.

Immediate cause of death	Duration
Shock	1/2 hr.
Due to Operation	2 hr.
Due to	
Other Conditions Lung abscess, Rt	?

(Include pregnancy within 3 months of death)

Date of operation 6-22-45

Major findings of operation: Lung abscess

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 6-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G30109

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address W. Fayette St.

(c) Hospital or institution Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 535 Beaumont Av (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. John Farell Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/1888

8. AGE: Years 57 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Surf operator

11. Industry or Business Race Track

FATHER 12. Name John Farell Sr

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Roche

15. Birthplace Ireland

16 (a) Informant Mrs Farell

(b) Address 535 Beaumont Av

17 (a) Burial, cremation, or removal Dania (b) Date thereof 5/26/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Frederick Rd & Hilton St

18 (a) Funeral director Chas. J. Kelly & Sons

(b) Address 3182 Eastern Av

19 (a) (b) Date received by registrar JUN 24 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1945 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1945 to 6/21 1945 and that I last saw h alive on 6/21 1945

Immediate cause of death	Duration
Pneumonia & Cardiac	
Due to Carcinoma pylorus ?	
Due to	
Other Conditions Coronary Thrombosis	3 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~autopsy~~ Carcinoma of stomach & liver metastasis

~~autopsy~~: abdominal ascites

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature F. L. Schabel Jr. M. D.

Address Bon Secours Hosp. Date signed 6/22/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G30110 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3832 St Margaret St. (Brooklyn) Balto. Md.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (Brooklyn)
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3832 St Margaret St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Eleanor Orner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife William F Orner

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 10, 1895

8. AGE: Years	Months	Days	If less than one day
50	3	13	hr. min.

9. Birthplace Harrisburg, Penna.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Harry E Stoner

13. Birthplace Penna.

MOTHER

14. Maiden Name Anna M Kline

15. Birthplace Dauphin, Penna.

16 (a) Informant William F Orner

(b) Address 3832 St Margaret St. Balto. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Rolling Green

Location Lemoyne, Penna.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St Paul St. Balto., Md.

19 (a) JUN 25 1945 registered (b) Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945, to June 23 1945, and that I last saw h[illegible] alive on June 23 1945.

Immediate cause of death	Duration
Cardiac Asthma	1 Da
Due to Pareinal Bronch. Infection & Emphysema	5 yrs
Due to Uremia & Nephritis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Rooney M.D.

Address 2022 St Paul St Date signed June 24/45 M. D.

VS 150

X

G30111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30111 Registered No. 937

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 E. LOMBARD ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 E. LOMBARD ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNIE M. KNOERLEIN
3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: GEORGE KNOERLEIN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) AUG. 16 1883
8. AGE: Years 61 Months 10 Days 5 If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name CHARLES B. BALL
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ANNA KUECHREITER
15. Birthplace GERMANY

16 (a) Informant GEORGE KNOERLEIN (HUS.)
(b) Address 3510 E. LOMBARD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 25/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Gutenkauf
(b) Address 403 S. WOLFE ST.

19 (a) JUN 25 1945 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 21 1945 at 7/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23-19XX, to 6-21-1945. and that I last saw h[illegible] alive on 6-21 1945.

Immediate cause of death: Cerebral Thrombosis — Duration: 3 days
Due to: arteriosclerosis
Due to:
Other Conditions: arteriosclerotic heart disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Constantine, M.D.
Address 234 S. Conkling St. Date signed 6-22-1945

X

G30112

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G30112

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park Drive
(c) Hospital or institution:
U S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 10 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Ny (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Bowery
(If rural give location)
(e) Citizen of foreign country? China (Yes ~~or No~~)
If yes, name country China

3 (a) FULL NAME Ah Choy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	yellow	married

6 (b) Name of husband or wife Unn See
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug 9. 1884

8. AGE: Years	Months	Days	If less than one day
60 60	10	14	hr. min.

9. Birthplace China
(Town, county, and state)
10. Usual Occupation steward
11. Industry or business

FATHER
12. Name Fu Chay
13. Birthplace China

MOTHER
14. Maiden Name Dz See
15. Birthplace China

16 (a) Informant: Kwong Kinau
(b) Address 12 Bowery N.Y.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26, 45 (Month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location New York City
18 (a) Funeral director A. Lee Oden
(b) Address 4644 York Road
19 (a) 6/25/45 Huntington Md. (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 1945 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945 to June 23 1945 and that I last saw h[illegible] alive on June 23 1945.

Immediate cause of death Adenocarcinoma of Stomach
(No statistical value Carcinomatosis)
Due to Generalized ~~St~~.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph A. Stahl M.D.
Address U.S. Marine Hosp Baltimore Md. Date signed 6/24/45

VS 150

G30113

BALTIMORE CITY HEALTH DEPARTMENT ✓ G30113

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Hospital for the Women of Maryland 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12 Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Minnie Ida Ida Johnstone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1863

8. AGE:

Years	Months	Days	If less than one day
81	11	0	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business At home

FATHER
12. Name Dr. John T. King
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Sallie Hyland
15. Birthplace Somerset Co. Md.

16 (a) Informant Mrs. L. T. Lewis
(b) Address 7200 Ridge Blvd Brooklyn N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Stone Chapel
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JUN 25 1945 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 23 1945, and that I last saw her alive on June 23 1945.

Immediate cause of death Coronary Thrombosis

Due to Left Bundle Branch Block

Due to Arteriosclerosis, Hypertension

Arteriosclerotic Heart Disease

Other Conditions Hypertension, Cardiac Vascular Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Speed III M. D.
Address Women's Hospital Date signed 6-23-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 630114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2319 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert N Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1873

8. AGE: Years 71 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace St Mary's County Md. (Town, county, and state)

10. Usual Occupation Streetcar Motorman

11. Industry or business B R T Retired

FATHER
12. Name James T Milburn
13. Birthplace St Mary's County Md.

MOTHER
14. Maiden Name Clara
15. Birthplace St Mary's County Md.

16 (a) Informant Lloyd A Milburn
(b) Address 2319 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar-Hill
Location Anne-Arundel County, Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St., Balto., Md.

JUN 25 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19, 1944 to June 22 1945 and that I last saw h[illegible] alive on June 22 1945

Immediate cause of death: Chronic Myocarditis — Duration

Due to Arteriosclerosis

Due to Varicose Ulcers Leg

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Tenley M. D.

Address 441 S. Ellwood Av Date signed 6/23/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30115

HEP - 94096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G30115

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals 1811

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 927 West Fayette St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Yancey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1945

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Robert Yancey

13. Birthplace Virginia

MOTHER

14. Maiden Name Helen Mackey

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Avenue

17 (a) Cremated 3PM (b) Date thereof 6-20-1945
(~~Burial~~, cremation, ~~or removal~~) (month) (day) (year)

(c) ~~Cemetery or~~ crematory Balto. City Hosp.

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (~~Filed~~) JUN 25 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945 at 2:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10, 1945 to June 17, 1945 and that I last saw her alive on June 17, 1945.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: at. atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John R. Brumgham M.D.

Address BCH Date signed 6-22

VS 150

G30116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30116 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. O. A.
(b) Street address 2006 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Dallinger

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Roumania
(Town, county, and state)

10. Usual Occupation Cleaning & Repairing

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Roumania

MOTHER
14. Maiden Name Alta
15. Birthplace Roumania

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 6-25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wash. Mt.
Location Wash. Blvd

18 (a) Funeral director Jack Levis Inc
(b) Address 1439 E. Balto St

19 (a) JUN 25 1945 Huntington Williams Mort
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1945, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 6/25/45

937

G30117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

G30117

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 N. Charles St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) --12-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Mrs. Margaret Nichols Neild

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ##### John Howard Neild
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) July 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	6	--- hr. --- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Patrick Nichols
13. Birthplace Ireland

MOTHER
14. Maiden Name Honora Durkin
15. Birthplace Ireland

16 (a) Informant Miss Marie Neild
(b) Address 2700 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery ###### Druid Ridge
Location Baltimore, Md.

18 (a) Funeral director H. H. Mares & Son
(b) Address 805 N. Calvert St.

JUN 25 1945 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1945, to June 24 1945, and that I last saw her alive on June 24 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days,
Due to Cerebral Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry B. Ashby M. D.
Address 2504 St Paul St. Date signed 6/25/45

G30118 ✓ G30118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Franklin St. (If rural give location)
(e) Citizen of foreign country? W (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6 1918

8. AGE: Years 27 | Months 2 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Wilson
13. Birthplace S. C.

MOTHER 14. Maiden Name Rose Gamble
15. Birthplace S. C.

16 (a) Informant Mr. Wilson
(b) Address 1701 Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-45 (month) (day) (year)
(c) Cemetery or crematory Florence
Location S. C.

18 (a) Funeral director A. C. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Date received (year) (b) Huntington Williams Registrar

JUN 25 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 45 to 6/24 1945 and that I last saw h[illegible] alive on 6/24 1945

Immediate cause of death Pulmonary Tuberculosis | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Heath X M. D.
Address [illegible] Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30119

BALTIMORE CITY HEALTH DEPARTMENT ✓ G30119

CERTIFICATE OF DEATH 131a

Registered No.

G30119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1038 Penna. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 ✓✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Penna. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Barfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and State)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lila Hairston
(b) Address 1038 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Chas - Law.

18 (a) Funeral director ~~C. Probst~~ ~~Bell Funeral Home~~
(b) Address ~~2600 Pennsylvania Ave~~ 802 Madison Ave Huntington Williamsport, Md.

19 (a) (Date received by registrar) JUN 25 1945 Registrar

VS 150

MEDICAL CERTIFICATION 10

20. DATE OF DEATH June 22, 1945 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1945 to 6/22 1945
and that I last saw h[illegible] alive on 6/20 1945

Immediate cause of death Hypostatic Pneumonia Cardio Renal disease — Duration 6 mos 1 day

Due to Uremia Coma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Cool Arlington Date signed 6/25

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G30120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? / (Yes or No) If yes, name country

3 (a) FULL NAME Matilda Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 76 Months - Days - If less than one day hr. min.

9. Birthplace Toronto Canada (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace

MOTHER
14. Maiden Name Matilda Myers
15. Birthplace -

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore.

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b) Registrar

JUN 25 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 - 1945, at 9-30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1943, to June 23 1945, and that I last saw her alive on June 22 - 1945

Immediate cause of death	Duration
Edema Lungs	1 day
Due to: Carcinoma of Stomach	1 year
Due to:	
Other Conditions Metastasis in Lungs (Include pregnancy within 3 months of death)	3 months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. Northern Date signed 6/25/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1639

G30121 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 S. 45th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Joseph Michalski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-0159

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1899

8. AGE: Years	Months	Days	If less than one day
45	9	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business Bethlehem Steel

FATHER
12. Name Marcel Michalski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Rydzewski
15. Birthplace Poland

16 (a) Informant Mrs. Elizabeth Michalski
(b) Address 524 S. 45th Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-26-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rozary
Location Baltimore md

18 (a) Funeral director George A. Weber
(b) Address 745 Ann st.

19 (a) JUN 25 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1945, at 9:20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Tetrachloride Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-21-45 at M.
(b) Where did injury occur? 524 S. 45th Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Swallowed cleaning fluid

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed June 23, 1945

VS 151

G30122 - 86956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G30122 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 3 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2441 Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mark Grafton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Mark Grafton (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jones (D)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location North & Greenmount Ave.

18 (a) Funeral director John M. Pickerelle Sons, Inc.
(b) Address 1400 Eutaw Place

19 (a) JUN 25 1945 (b) Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1945, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 1944, to June 16 1945, and that I last saw him alive on June 16 1945.

Immediate cause of death: Bronchopneumonia — Duration 2 days
Due to: Hypostatic congestion
Due to:
Other Conditions: Arteriosclerosis, general & cerebral
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Mudlapp M. D.
Address Baltimore, Md. Date signed 6-27-45

VS 150

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630123

TOLAND-

630123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5802 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5802 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Toland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Fe | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 13, 1860

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Boston, Mass
(Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER
12. Name James Toland
13. Birthplace Phila, Pa.

MOTHER
14. Maiden Name Sarah A. Collins
15. Birthplace England

16 (a) Informant Mrs Susie Leitch
(b) Address 5802 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem
Location North Greenmount Ave

18 (a) Funeral director John O Mitchell & Son
(b) Address 1900 Eutaw Place, (Huntington Williams, M.D.)

JUN 25 1945 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to June 24 1945
and that I last saw her alive on June 24 19 45

Immediate cause of death Carcinoma, rectum — Duration 1 year

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature E L Jennings M.D.
Address 230 Medical Arts Bldg. Baltimore Md. Date signed 6/24/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G30124

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Prince Georges
(c) City or town Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Second St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs Anna Rose Upman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Francis X. Upman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

8. AGE: Years	Months	Days	If less than one day
78	0	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Ferdinand DeDay
13. Birthplace France

MOTHER
14. Maiden Name Catherine Baltz
15. Birthplace Germany

16 (a) Informant Mrs Violet M Corbett
(b) Address 107 Sudbrook Lane, Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director Sanpo & Farley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS JUN 25 1945

MEDICAL CERTIFICATION

20. **DATE OF DEATH** June 23, 1945, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1945 to June 23 1945, and that I last saw h[illegible] alive on June 23 1945

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Perforated Gastric Ulcer	20 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 23, 1945
Major findings of operation: Perforated Gastric Ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 6/25/45 M.D.

X

G30125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30125

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 948 N. Duncan St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Riger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1857

8. AGE: Years	Months	Days	If less than one day
88	2	14	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name Geo Riger
13. Birthplace Md

MOTHER
14. Maiden Name Mary L. Sharp
15. Birthplace Md.

16 (a) Informant Mrs Lena Reeves
(b) Address 948 N Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location End of East North Ave

18 (a) Funeral director John F Cowan & Son
(b) Address 901-03 W Pratt St

19 (a) JUN 25 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1945 at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to Arteriosclerotic C. V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 6/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30126 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) City ~~County~~ of Baltimore

(c) City or town ~~Baltimore~~ Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 2908 Whitney Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Edwin Deady Livingston

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: no

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bessie Fox Livingston

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 4-26-80

8. AGE: Years 65 | Months 1 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation None (retired)

11. Industry or business

FATHER

12. Name Edwin C. Livingston

13. Birthplace Front Royal, Va.

MOTHER

14. Maiden Name Emma Deady

15. Birthplace Abingdon, Va.

16 (a) Informant Hosp. chart

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Butler, Md.

18 (a) Funeral director Wm. J. Pickens & Son

(b) Address Butler, Md.

19 (a) ____ (b) ____ (Date rec'd by registrar) Registrar

JUN 26 1945

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1945 12:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24 1945 to 6-24 1945 that I last saw him alive on 6-24 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Frank Supplee III M. D.

Address Union Memorial Hospital Date signed 6/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: Church Home & Hosp. 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 E North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PRISCILLA SYDNEY WALLACE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Charles C. Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1858

8. AGE: Years	Months	Days	If less than one day
87	2	24	hr. min.

9. Birthplace Maryland. (Balto.) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Ransdam
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Clark
15. Birthplace Maryland.

16 (a) Informant Mr. Clarence C. Wallace
(b) Address 1641 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Wellington Williams, Mgr.

19 (a) JUN 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-23-45 19 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1945 to 6-23 1945, and that I last saw her alive on 6-23 1945.

Immediate cause of death	Duration
Pulmonary edema	2 days
Due to Arteriosclerotic Cardiovascular Disease	?
Due to	
Other Conditions Pulmonary arterial embolus - st reg. (Include pregnancy within 3 months of death)	3 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Steven Hatch M. D.
Address C. N. H. Date signed 6-25-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G30128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway & Fairmount
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5504 Key Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Virginia Hendrickson

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1881

8. AGE: Years 63 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation School teacher - retired
11. Industry or business Balto. Co.

FATHER
12. Name John F Hendrickson
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Olivia Gates
15. Birthplace Washington D.C.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER Hillsman Mgr
(b) Address Balto., Md.

19 (a) (Date received by registrar) JUN 25 1945 Registrar

VS 169

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1945, to 6-23 1945, and that I last saw her alive on 6-23 1945.

Immediate cause of death: Immediate — Duration

Due to Carcinoma of cecum with metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation June 1945
Major findings of operation: Inoperable Carcinoma of cecum with metastasis
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steiner Hall M. D.
Address C. H. H. Date signed 6-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30129

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2541 Francis St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2541 Francis (If rural give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country

3 (a) FULL NAME Flora Adele Dandtholtz

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-18-6311

4. Sex F

5. Color or race cw

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband ~~or wife~~ George P. Dandtholtz

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 29-1880

8. AGE: Years 65 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Keller matron

FATHER 12. Name Chas. F. Falkenstein

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Laura Belt

15. Birthplace Manchester Md.

16 (a) Informant Miss Ruth Falkenstein

(b) Address 2742 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Huntington Ave. & Northern Pky. Md.

19 (a) JUN 25 1945 (b)

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 22 1945, and that I last saw h. alive on June 22 1945.

Immediate cause of death	Duration
Cerebral Hemorrage	6/18/45
Due to	
Due to Chr. Myocarditis	1943
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Brown

Address 1630 N. North Ave. Date signed 6/23/45 M. D.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30130 — BALTIMORE CITY HEALTH DEPARTMENT — G30130 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) City of Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. 25th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar A. Fergusson

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Edith H. Fergusson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-80

8. AGE: Years	Months	Days	If less than one day
64	8	10	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Baggage Service PRR

11. Industry or business

FATHER
12. Name Cutler Fergusson
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Fergusson
15. Birthplace Maryland

16 (a) Informant Hosp. chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-23 1945, at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945, to 6-28 1945, and that I last saw him alive on 6-23 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Coronary thrombosis & infarction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Geo. W. Mungatings Jr. M. D.
Address 332 W. Lanvale Pl. Date signed 6/23/45

VS 150

JUN 25 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Lexington Park

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30131 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 811 N. Chester

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 811 N. Chester St (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Minnie Huether

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Daniel Huether

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1874

8. AGE: Years 70 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John Otto

13. Birthplace Md

MOTHER 14. Maiden Name Eliz. Peterman

15. Birthplace Maryland

16 (a) Informant Lewis Huether

(b) Address 811 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-43 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Balto Md

18 (a) Funeral director Mark Bradbon

(b) Address 1815 Chester St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1943, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1942 to June 22 43 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	6/19/43
Due to Ch. Myocard. Ds	7/1/42
Due to Arterio Sclerosis	1943
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Rosario M. D.

Address 901 E Lemmon St Date signed 6/23/43

JUN 25 1943

VS 150

G30132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30132
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 661 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Comis

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband~~ or wife: Anna Comis

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 63 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual Occupation: Retired Veteran
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant: John Griehen
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)
(c) Cemetery or crematory: Arlington, Va.
Location: Arlington Va.

18 (a) Funeral director: Charles W Tuckerman
(b) Address: 637 Woodington Blvd.

19 (a) (b) Huntington Williams M.D. (Date rec'd by Registrar) (Registrar)

JUN 28 1945

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 19 45, at 1.10 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to

Other Conditions: Hypertensive Cardio-vascular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Hugh W B McNally M.D. (Medical Examiner)
Date signed 6/23/45

G30133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43 B

G30133 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N Lakewood a
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N Lakewood Ea
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James G. Bierlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~ Marr

6 (b) Name of husband or ~~wife~~ Alice L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30 1872

8. AGE: Years 66 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace A.A. Co. MD
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Engineer Penn RR

FATHER
12. Name John Bierlein
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Gough
15. Birthplace Baltimore Md

16 (a) Informant Alice L Bierlein
(b) Address 102 N Lakewood Ea

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24
(month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John G Moran
(b) Address 3000 E Baltimore
Huntington Williams

19 (a) (Date rec'd by registrar) (b)

JUN 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 5 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940, to June 22 1945, and that I last saw him alive on June 22 1945.

Immediate cause of death (Pulmonary Tuberculosis Bilateral with Cavities.)
Due to Tubercle Bacilli

Due to —

Other Conditions arterio-S Illness + Hypertension —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —

of autopsy: —

Duration
12 yrs.
5 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumeich M. D.
Address 722 N. Kenwood Date signed June 23/45

X

G30134 — BALTIMORE CITY HEALTH DEPARTMENT — G30134

CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo, 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~County~~ City of Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles A. Ogle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name ~~of husband~~ or wife Mrs. Charles A. Ogle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-83

8. AGE: Years	Months	Days	If less than one day
61	10	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Suit clerk
11. Industry or business

FATHER
12. Name Francis Ogle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Hartmen
15. Birthplace Germany

16 (a) Informant Hosp. chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27-45 (month) (day) (year)
(c) Cemetery or crematory Pt. Lorraine
Location Eastern Ave Road
18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto. St.
(c) Huntington Williams M.D. (Registrar) Registrar

JUN 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 1945, at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1945, to 6-23 1945, and that I last saw him alive on 6/23 1945.

Immediate cause of death Cardio-Resp failure — Duration

Due to Cirrhosis of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm W. Hodges M.D.
Address Union Mem. Hosp. Date signed 6/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30135

Frederickshauser

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 12 13

Registered No. G30135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Fraebertshauser

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1891

8. AGE: Years 53 | Months 9 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Francis Bowman
13. Birthplace Unknown

MOTHER
14. Maiden Name Rose Sauge
15. Birthplace Md.

16 (a) Informant James Fraebertshauser
(b) Address Finksburg Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28-45 (month) (day) (year)
(c) Cemetery or crematory Leisters
Location Carroll Co

18 (a) Funeral director J. F. Elmer Sons
(b) Address Westminster Md.

19 (a) ... (b) Huntington Williams M.D. (Local registrar) Registrar

JUN 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1945, to 6/25 1945, and that I last saw h[illegible] alive on 6/24 1945.

Immediate cause of death: Cerebral collapse — Duration

Due to Uremia

Due to Chronic Glomerular nephritis

Other Conditions Anemia, Chronic glomerulo nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Goldstein M.D.

Address University Hosp. Date signed 6/25/45

G30136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G30136

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 755 No. Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Barns Wolfe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ora B. Wolfe

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James C. Wolfe
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Sandfield
15. Birthplace Virginia

16 (a) Informant Ora B. Wolfe
(b) Address Manchester, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)
(c) Cemetery or crematory St. Paul Cem.
Location Baltimore County, Md.

18 (a) Funeral director Jacob Wink's Sons
(b) Address Manchester Md.

6-25-1945 (c) Filed by registrar (d) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed June 24 1945

G30137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30137 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Balto. Eye, Ear, Throat Charity Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elva B. Muhl

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife H J. H Muhl
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June. 9-1885

8. AGE: Years	Months	Days	If less than one day
60	-	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name E S. Hunt
13. Birthplace Maryland

MOTHER
14. Maiden Name Kelthley
15. Birthplace Maryland

16 (a) Informant H J H Muhl
(b) Address 1715 S Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto City

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Division St

(a) June 25 1945 Huntington Williams Registrar
VS 3 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945 to June 24 1945 and that I last saw her alive on June 23 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Renal d.	
Due to Coronary Thrombosis	3 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Removal of Cataract Left eye.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas Fenner
Address 11 E. Eden St Date signed M. D.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is important. Physicians: please write the causes of death clearly and legibly.

G30138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G30138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N. Brice
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Brice
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stella Papa

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife late Antonio Papa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1858

8. AGE: Years 87 | Months 1 | Days 23 | If less than one day: hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Antonino Marsiglia
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela D'Anna
15. Birthplace Italy

16 (a) Informant Anthony Papa (Son)
(b) Address 4411 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25/45 at 5:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20/45 to 6/25/45 and that I last saw h[illegible] alive on 6/24/45

Immediate cause of death Carcinoma of face — Duration 2 yr

Due to carcinoma of face

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. D'Amico M. D.
Address Medical Arts Bldg Date signed

VS 150

G30139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G30139 Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St Joseph's Hospital 81
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Cliftwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Leonard Harvey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-8188

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Harvey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4th 1892

8. AGE: Years 52 | Months 10 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Allied Paper Bag Co

FATHER
12. Name Zachary Harvey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Collins
15. Birthplace Va.

16 (a) Informant Mary E. Harvey
(b) Address 2124 Cliftwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JUN 26 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25/45 19..., at 8:20 AM

21. I certify that I took charge of the remains described above, held an Inspection of Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Harry E. Davis, M.D. Medical Examiner.
Date signed 6/25/45

Dr. Benj. Miller 2030 Wilkens Ave Si 4306 ✓

G30140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30a

G30140 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 Mc Henry st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Mc Henry st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annabelle B. Seets ✓

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: George Seets
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1877

8. AGE: Years 68 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Jacob Sable
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Florence Ament
(b) Address 2018 Mc Henry st

17 (a) Burial (b) Date thereof 6/28/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 (d) JUN 26 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/44 19 to 6/24 19 45 and that I last saw her alive on 6/24 1945.

Immediate cause of death: Tabes dorsalis
Antero lateral Cranial disease

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens Ave Date signed 6/24/45 ✓

G30141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 ✓

Registered No. G30141

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Harford Rd + Hennig Run

(c) Hospital or institution: Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1809 St. Paul St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Riddlemoser, John Richard ✓

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1944

8. AGE: Years: 1 | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER

12. Name Robert Lee Riddlemoser

13. Birthplace Baltimore

MOTHER

14. Maiden Name Betty Schaller

15. Birthplace Baltimore

16 (a) Informant Mrs. Robert L. Riddlemoser

(b) Address 1809 St. Paul St., Baltimore

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/26/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 JUN 26 1945 (b) Registrar

(Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1945, to June 25 1945, and that I last saw him alive on June 25 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Waterhouse-Friderichsen syndrome	5 hrs.
Due to Meningococcemia	15 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Smith M. D.

Address Sydenham Hosp Date signed 6-25

X

G30142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G30142

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Remley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 Remley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John V. Potts

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Bertha Potts
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1890

8. AGE: Years 54 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Arundel Corp.

FATHER
12. Name William F. Potts
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Mary Kelbaugh
15. Birthplace Pa.

16 (a) Informant (wife) Bertha Potts
(b) Address 3320 Remley Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/28/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25- 1945, at 5-30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to June 25 1945, and that I last saw h[illegible] alive on June 18 1945.

Immediate cause of death Cirrhosis of Liver — Duration 1 yr.?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Linton M. D.
Address 320 Pikesville Date signed 6/27/45

VS 150

G30143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G30143
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Jones St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brandt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1/24 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Brandt
13. Birthplace

MOTHER
14. Maiden Name Pauline Anderson
15. Birthplace Iowa

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 26 1945 Huntington Williams, M.D.
(Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1945 to 6/14 1945, and that I last saw h/m alive on 6/14 1945.

Immediate cause of death: Prematurity, 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert T. Mark M. D.
Address Date signed 6/20

VS 150

F2780

G30144

Ba-26261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30144

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton and Wilkens Sts

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1917 Herbert St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Geppi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 5 hr. 15 min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel V. Geppi

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Marie Buettner

15. Birthplace Balto. Md

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL JUN 21 1945

Location

18 (a) Funeral director Commissioner of Health

(b) Address

JUN 26 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 19 45 at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 19 45 to 6/17 19 45

and that I last saw her alive on 6/17 19 45

Immediate cause of death	Duration
Respiratory failure	
Due to Immaturity (20 wks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature José A. Alvarez de Landero M. D.

Address St Agnes Hospital Date signed 6-17

VS 150

2779

X

G30145

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G30145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11da
(e) Length of stay in Baltimore (yrs., mos., or days) 11da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/45

8. AGE: Years | Months | Days: 11 | If less than one day: hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Walter Harris
13. Birthplace

MOTHER
14. Maiden Name Olra Brown
15. Birthplace Va.

16 (a) Informant Olra Harris.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 26 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945 to 6/14 1945 and that I last saw her alive on 6/14 1945.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sam L. Kyrkberg Jr. M. D.

Address Date signed

VS 150

12.78

G30146 For City Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30146 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14da
(e) Length of stay in Baltimore (yrs., mos., or days) 14da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1403 N Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Harris "B"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/45

8. AGE: Years | Months | Days 14 | If less than one day hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Walter Harris

13. Birthplace

MOTHER 14. Maiden Name Olra Brown

15. Birthplace Va.

16 (a) Informant Olra Harris

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 21 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 26 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945 to 6/17 1945, and that I last saw he alive on 6/17 1945

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions Diarrhea

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. L. Hockey Jr. M. D.

Address Univ. Hosp Date signed 6/17/45

VS 150

T 2777

G30147 BALTIMORE CITY HEALTH DEPARTMENT G30147
CERTIFICATE OF DEATH 93 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3226 Dudley a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3226 Dudley a (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes S. Martini

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George

6 (c) If alive, give age 1875 years

7. Birth date of deceased (mo., day, yr.) Feb. 8 1870

8. AGE: Years 70 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Farrell
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Cassully
15. Birthplace

16 (a) Informant John J. Martini
(b) Address 3226 Dudley a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jun 27-45 (month) (day) (year)
(c) Cemetery or crematory New Health
Location Old Frederick Rd.

18 (a) Funeral director John A. Mc Gann
(b) Address 3000 E. Balto.

19 (a) (Date rec'd by registrar) JUN 26 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1945, to June 24 1945, and that I last saw h[illegible] alive on June 24 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage Chronic Nephritis	5-16-45
Due to Congenital Failure	6-1-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ed Schmunk M. D.
Address 1412 E. Eager Date signed 6-25-45

VS 150 (over)

G30148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G30148 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Ailsa Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Ailsa Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (DORA) DOROTHEA ELIZABETH SEIPP

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George A. Seipp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1869

8. AGE: Years	Months	Days	If less than one day
76	2	3	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Seippel
15. Birthplace Germany

16 (a) Informant Mrs. Raymond C. Ashley
(b) Address 3008 Ailsa Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19. JUN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1945, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945, to June 23 1945, and that I last saw her alive on June 23 1945.

Immediate cause of death	Duration
Cardiac Dilatation	1 Day
Due to Aortic Insufficiency	
Arterial Hypertension	1 Year
Degenerative Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert C. Isenberg M. D.
Address 202 E. North Ave. Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G30149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) BORN
(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIM
(c) City or town TOWSON.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E. BURKE AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME HARRIET PATTISON HANN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband ~~or wife~~ HAROLD C. HANN.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 8, 1888

8. AGE: Years 56 | Months 11 | Days 17 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOUSEWIFE.

FATHER
12. Name WILBUR F. SMITH.
13. Birthplace Loudon CoVIRGINIA

MOTHER
14. Maiden Name MARGARET PAITISON
15. Birthplace TaylorsIs MARYLAND

16 (a) Informant HUSBAND - HAROLD C. HANN.
(b) Address 14E BURKE AVE. TOWSON, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto 45 Md.

19 (a) JUN 26 1945 (Date rec'd by registrar) (b) Thurlington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25- 1945, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17- 1945 to 6-25- 1945 and that I last saw her alive on 6-25- 1945.

	Duration
Immediate cause of death: CARDIO-RESP FAILURE	2½ HRS.
Due to CONGESTIVE HEART FAILURE	7 DAYS.
Due to RUPTURED APPENDIX	8 DAYS.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-17-45

Major findings of operation: RUPTURED GANGRENOUS APPENDIX.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D.
M. D.
Date signed 6-25-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47535 G30150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G30150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. Denmiam & Eolgan Ave 3214 Elgin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Counselman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-71

8. AGE: Years	Months	Days	If less than one day
73	10	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired School Teacher

11. Industry or business

FATHER
12. Name Robert Counselman
13. Birthplace Md.

MOTHER
14. Maiden Name Rosina Davis
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto.

18 (a) Funeral director Wm. J. Tideman & Son
(b) Address Balto Md.

19 (a) JUN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 25 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June - 12 1945, to June - 25 1945, and that I last saw her alive on June - 25 1945.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Hypertension and arteriosclerosis and	
Due to Anemia due to g.i. hemmorhage.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rosa L. McLean M. D.
Address J.H.H. Date signed 6/25/45

VS 150

G30151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30151
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 Presstman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Presstman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard N. Garrison

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-8533

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Garrison
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1901

8. AGE: Years	Months	Days	If less than one day
44	8	25	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Welder
11. Industry or business

FATHER
12. Name William Garrison
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Blanche Johnson
15. Birthplace Balto Md.

16 (a) Informant Mary Garrison
(b) Address 527 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) (b) Huntington Williams, Md
Registrar

JUN 26 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1945, to June 23 1945, and that I last saw him alive on June 23 1945.

Immediate cause of death: Lobar Pneumonia — Duration: 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature William Frey, M.D.
Address 121 Pa Ave Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G30152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 Stirling St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write in "Rural," and give town)
(d) Street No. 1305 Stirling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chas. E. Carroll

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie Carroll
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Howard Co. Md
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Annie Carroll
(b) Address 1305 Stirling St

17. Buried (b) Date thereof June 29 1945
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 463 N. Carey St

19 (a) JUN 26 1945 Huntington Williams
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23/45 1945 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/45 to 6/23/45, and that I last saw him alive on 6/20/45 1945

Immediate cause of death: Cerebral Hemorrhage — Duration Instant
Due to Ulcers Stomach — Rib —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 1 E Pleasant Date signed 6/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G30153 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2034 N. Bentalow St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2034 N. Bentalow St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Frumon

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gilbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Pike Hamilton Ave

18 (a) Funeral director Jack Levis Inc

(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JUN 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1945, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945 to June 25 1945; and that I last saw her alive on June 25 1945

Immediate cause of death: Carcinoma of Stomach Metastatic Carcinoma of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Wolfe M.D.

Address 1331 E. Monument Date signed 6-25-45

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30154

BALTIMORE CITY HEALTH DEPARTMENT ✓ 97

CERTIFICATE OF DEATH

G30154 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2523 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Belle Hendler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Isaac
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 87 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Reuben Lack
13. Birthplace Russia

MOTHER
14. Maiden Name Bleyman
15. Birthplace Russia

16 (a) Informant L. Manuel Hendler
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-45 (month) (day) (year)
JUN 26 1945
(c) Cemetery or crematory Herring Run
Location Philadelphia Rd & Bowleys Lane
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St
19 (a) (Date received by registrar) JUN 26 1945 Registrar Huntington Wilkinson M.D. Milton B. Kirk

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-45 19 . at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to June 25 1945, and that I last saw her alive on June 24 1945.

Immediate cause of death: Cerebral arteriosclerosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 2904 Reed Rd Date signed 6/27/45

VS 150

G30155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G30155
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Catonsville
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Ramsey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Stephen Hixenbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6th 1859

8. AGE: Years	Months	Days	If less than one day
86	2	19	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business Farming

FATHER
12. Name Stephen Hixenbaugh
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Donna Rymel
(b) Address 1929 Ramsey St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Martinsburg
Location W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 27 E. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 26 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1945 to 6/25 1945 and that I last saw him alive on 6/25 1945.

Immediate cause of death Cardiac failure

Duration

Due to Myocardial Cardiac Vascular disease

Due to Fx

Other Conditions Fracture of right femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 20/3
(b) Date of occurrence June 18, 1945
(c) Where did injury occur? 1929 Ramsey St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No (Specify type of place)
(e) Means of injury Fall at home

23. Signature Jack Avery Jr Chandler M. D.

Address Date signed

X Howard J. Madden, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G30158~~ G30156
5111 York Road.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G30156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 E. 41st St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 E. 41st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Lay.

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow.

6 (b) Name of husband or wife John Lay.

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) June 19, 1871

8. AGE: Years 74 | Months - | Days 4 | If less than one day hr. min.

9. Birthplace Canada
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Alfred E. George
13. Birthplace England

MOTHER
14. Maiden Name Martha Francis.
15. Birthplace England.

16 (a) Informant Mrs. Clarence Frock.
(b) Address 817 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Edmonds P. Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JUN 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to June 23 1945 and that I last saw her alive on June 16 1945.

Immediate cause of death	Duration
Myocarditis	2 yrs
Due to Endocarditis	10 yrs
Due to Arteriosclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl J. Benson, M.D.
M. D.
Address 5111 York Rd Date June 25, 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G301557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G301557 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 S. Wilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry E. Mitchell Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-4251

4. Sex Male | 5. Color or race White | 6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife Audrey A.

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Feb 21 1906

8. AGE: Years 39 | Months 4 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Delivery man

11. Industry or business Wilton Farms Dairy.

FATHER
12. Name Harry E. Mitchell Sr.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Anna M. Neidoff.
15. Birthplace Maryland

16 (a) Informant Audrey A. Mitchell
(b) Address 245 S. Wilton St.

17 (a) Burial (b) Date thereof June 28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road.

18 (a) Funeral director Rhinowitz & Donovan
(b) Address 3615-17 Edmondson Ave.

19 (a) Huntington Williams, M.D.
Registrar

JUN 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 19 45, at 1055 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 19 45 to 6/24 19 45
and that I last saw h im alive on 6/24 19 45
Immediate cause of death Cardiac failure — Duration

Due to Pulmonary Embolus

Due to Generalized Arteriosclerosis

Other Conditions over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Not done
of autopsy: Autopsy refused by family

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Gratty Ellis M.D.
Address St Agnes Hosp Date signed 6-24-45
Cliff Ratliff X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~Dr~~ G30158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G30158 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Union Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred E. Whitmer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. H. Whitmer

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec 5 1897

8. AGE: Years 47 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. H. Naylor.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Estella M. Brooks.
15. Birthplace Maryland.

16 (a) Informant Wm. H. Whitmer
(b) Address 813 Union Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Shanower & Donovan
(b) Address 3615-17 Huntington Ave

19 (a) (Date received by registrar) (b) Huntington Hillcrest, M.D.

JUN 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 45 at 3 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/45 19 to 6/24 19 45
and that I last saw h er alive on 6/24 19 45.

Immediate cause of death carcinoma of pleura — Duration 4 mo.
Due to Metastasis Liver, Lungs, Abdomen
Due to
Other Conditions
Operation removal
(Include pregnancy within three months of death)
Date of Operation
Major findings of operation:
carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 20 E. Lanvale Date signed 6/25/45

X

G30159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CWK-94301

CERTIFICATE OF DEATH 122a

G30159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6608 Fait Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sanatore Samuel Leone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annette Leone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15-1885

8. AGE: Years 59 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-1945 (month) (day) (year)
(c) Cemetery ~~crematory~~ Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director Leo D. Leach
(b) Address 1701-03 N Patterson Park ave

JUN 26 1945 (Date rec'd by registrar) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 5:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1945, to June 25 1945, and that I last saw him alive on June 25 1945.

Immediate cause of death: Uremia Bronchopneumonia — Duration 5-6 days
Due to: pyelonephritis — Duration ?
Due to: — Duration
Other Conditions: paralytic ileus — Duration 2 days
(Include pregnancy within 3 months of death)

Date of operation 6-21-45
Major findings of operation: incarcerated hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hoyah E. Bolton
Address City Hosp. Date signed 6/25/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30160

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 S Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 S Washington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Hohman

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 187

8. AGE: Years 68 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Sebastian Hohman
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Germany

16 (a) Informant John H. Endres
(b) Address 107 S. Washington St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. C. Dippel's Sons
(b) Address Lombard & Ann Sts.

19 (a) (Date received by Registrar) (b) JUN 26 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1945 to June 24 1945 and that I last saw h[im] alive on June 24 1945.

Immediate cause of death

Due to Acute Coronary Occlusion acute

Due to Coronary arteriosclerosis ?
Chr. Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address 500 N Pulaski Date signed 6/25/45

Huntington Printing Co., Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30161 — BALTIMORE CITY HEALTH DEPARTMENT — G30161

CERTIFICATE OF DEATH 131a

Registered No. G30161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 442 E 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 442 E 23rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Allen Kinney
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 2, 1921
8. AGE: Years: 24 | Months | Days | If less than one day: hr. min.
9. Birthplace Bel Air Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ora F. Kinney
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Burrell
15. Birthplace Va

16 (a) Informant Martha Kinney
(b) Address 442 E 23rd St.
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location A. A. County
18 (a) Funeral director Mrs. Robert A. Ellis, Dgt.
(b) Address 1129 N. Caroline St
19 (a) (Date received by Registrar) JUN 26 1945 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th 1945 at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 25th 1945 and that I last saw h alive on June 25 1945.

Immediate cause of death	Duration
Cardio. Renal Disease	
Due to Rheumatic fever.	2½ Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eric A Salmon M. D.
Address 2329 Guilford Ave Date signed June 25 1945

N G30162

AB-92777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. G30162

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 29days

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5104 Division St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ignatius Stencel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31- 1870

8. AGE: Years	Months	Days	If less than one day
74	10 8	23	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Joseph Stencel

13. Birthplace Poland

MOTHER

14. Maiden Name MARTHA Butler

15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director H. Howard Strong

(b) Address 3427 W. North Ave.

19 (a) JUN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 9.17PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26- 1945, to 6-24 1945, and that I last saw h im alive on 6-24- 1945.

Immediate cause of death	Duration
TOXEMIA	3 WKS
CACHEXIA	"
Due to CARCINOMA ESOPHAGUS	6 MOS.
Due to	
Other Conditions ATHEROSCLEROSIS	YEARS

(Include pregnancy within 3 months of death)

Date of operation 5-22-45

Major findings of operation: GASTROSTOMY

of autopsy: ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. M. Cunningham

Address Balto City Hosp. Date signed 6-25-45 M. D.

X

G30163
AB-94342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G30163
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Brewer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Lillian Holmes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1873

8. AGE: Years 71 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis Brewer (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Laura McAbee (D)
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27 45 (month) (day) (year)
(c) Cemetery or crematory Loraine Blond
Location
18 (a) Funeral director Phipps Sterling Sons
(b) Address 2024 Eleana Ave
19 (a) JUN 26 1945 (Date received by registrar) Registrar
Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24- 1945, at 8.55AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23- 1945 to 6-24- 1945, and that I last saw him alive on 6-24- 1945.

Immediate cause of death Cardiac decompensation — Duration ?
Due to arteriosclerotic heart disease — Duration ?
Due to — Duration
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 6-25-45

VS 150

G30164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G30164

MARGIN RESERVED FOR BINDING. The entry item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2709 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: John W. Mitchell

3 (b) If veteran, name war: ***

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella L. Mitchell

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1868

8. AGE: Years 78 | Months 7 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Building Inspector

11. Industry or business Balto. City

FATHER
12. Name Uriah H. Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Riddle
15. Birthplace Md.

16 (a) Informant Miss. Grace S. Mitchell
(b) Address 2709 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Emanual
Location Seaggsville Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

(c) Date received by registrar JUN 26 1945 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 6.40 A. M

21. I certify that death occurred on the date above stated, and attended deceased from April 30th 1945 to June 24 1945 and that I last saw h[illegible] alive on June 23 1945.

Immediate cause of death Coronary Thrombosis Duration 6 weeks
arteio sclerotic clip pe heart disease with hypertrophy
Due to and congestive failure
Due to generalized arterio sclerosis.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Mitchell M. D.
Address 2901 Edmondson Ave Date signed June 26 '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193c

G30165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 La Salle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME anna Gardill

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Married

6 (b) Name of husband or wife Matthew Gardill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-80

8. AGE: Years	Months	Days	If less than one day
64	2	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Rudolph Frei.
13. Birthplace Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof 6/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto. Md.
Funeral director Lasasahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Date received by Registrar (b) Registrar

JUN 26 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6.25 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945 to 6.25 1945 and that I last saw h-r alive on 6.25 1945.

Immediate cause of death: Respiratory failure

Duration

Due to: Acute febrile illness

Due to: Unknown cause

Due to: Hypertensive rheumatic heart disease

Other Conditions: Cardiac failure Infarction of spleen

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Dixon
Address Johns Hopkins Hospital Date signed June 25 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G30166 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4119 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rebecca M. McComas

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	7	hr. min.

9. Birthplace Harford County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Evans F. Deckman
13. Birthplace Harford County, Md.

MOTHER
14. Maiden Name Jane A. Morrison
15. Birthplace Harford County, Md.

16 (a) Informant Ruth Hedges
(b) Address 4119 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Howard M. Blight, Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 26 1945

Huntington-Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 1945 at 11:P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1945 to 6/23 1945, and that I last saw her alive on 6/23 1945

Immediate cause of death Cerebral thrombosis — Duration

Due to Hypertensive arteriosclerotic disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert F. Bryan M.D.
Address 3215 Evelyn Pl Date signed M. 6/26/45 D.

X

G30167

AB-94543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G30167

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Willett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-?-1902

8. AGE: Years	Months	Days	If less than one day
42	7	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earnest Willett
13. Birthplace Md.

MOTHER
14. Maiden Name Whittington
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 27 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A & C

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston

19 JUN 26 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 24- 1945, at 6.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945, to 6-24 1945, and that I last saw h im alive on 6-24- 1945.

Immediate cause of death Central Hemorrhage

Duration 7

Due to Arteriosclerosis & hypertension cardiac

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 6-25-45

VS 150

G30168 G30168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Faulk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation City cleaning dept.

11. Industry or business

FATHER
12. Name Raphael.
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah.
15. Birthplace Russia

16 (a) Informant Joseph Faulk
(b) Address 602 E. St. Ramona Pl

17 (a) (Burial, [redacted]) (b) Date thereof 6/26/45 (month) (day) (year)
(c) Cemetery or crematory Montefiore Cemetery
Location Rockville

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E. Baltimore St.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

JUN 28 1945

VS 15f

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th 1945 at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an inspection + inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-25-45 at 1:20 P.M.
(b) Where did injury occur? Mercy Bldg. Balto. Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Fall from window

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 6-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30169 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 McCulloh
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Merrill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colrd | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nellie Merrill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years 69 68 | Months — | Days — | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John E. Merrill
13. Birthplace md

MOTHER
14. Maiden Name Eliza Broton
15. Birthplace md

16 (a) Informant Emma Staton
(b) Address 712 S. Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A Stayton
(b) Address 942 W Fred St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1, 20 1944 to 6/25 1945 and that I last saw h alive on June 23 45

Immediate cause of death — Duration

Due to Cardiac Renal — 7 hrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. J. Halsthan M. D.

Address 1 W Pleasant Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 58E

G30170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State N Dak. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 E. Heath St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Doris Juanita Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1939

8. AGE: Years	Months	Days	If less than one day hr.	min.
5	10	22		

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Walter
13. Birthplace Ind.

MOTHER
14. Maiden Name Beatrice ?
15. Birthplace Ind.

16 (a) Informant Family
(b) Address 3 E. Heath St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brook Lyn Ind
Lewis L. McCarthy
18 (a) Funeral director
(b) Address 130 S. Fort Ave.

19 (a) Huntington Williams M.D. (Date rec'd by registrar) Registrar

JUN 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23/1945, at 7.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945 to 6/23 1945 and that I last saw her alive on 6/23/1945.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Myocardial infarct.	
Due to Ac.-Rheum. fever Fibrinous pericarditis	fulminous
Other Conditions Pulm. Edema Bronchopneumonia, Bilat.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis H. Hirsh M.D.
Address Louis H. Hirsh Date signed 6/24/45
X STEINBERG

G30171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G30171

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Matthew St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Matthew St.
(If rural give location)
(e) Citizen of foreign country? Matthews (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA ELEONORA BORN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1880

8. AGE: Years	Months	Days	If less than one day
34	7	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name August Born
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Heinzerling
15. Birthplace Germany

16 (a) Informant Mrs. Jack Deming (Sister)
(b) Address 3004 Matthew St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June. 23. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore
18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & broadway

(a) JUN 26 1945 (Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1945 at 2.25P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1945 to June 23 1945, and that I last saw h alive on June 23 1945.

Immediate cause of death	Duration
Secondary Carcinoma	3 mo.
Due to Ca Liver	
Due to Carcinoma of Gall Bladder	3 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Apr 5 1945
Major findings of operation: Carcinoma of Gall Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. N. Meyer M.D.
Address 1520 E. 33rd Date signed 6/28/45 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G30172 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2936 Elliott Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2936 Elliott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER JOHN HENRY KOEHLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bertha Schlutter
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 17, 1872

8. AGE: Years	Months	Days	If less than one day
73	0	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Policeman, retired
11. Industry or business Balto. Police Dep't.

FATHER
12. Name Fred Koehler
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Geerky
15. Birthplace Germany

16 (a) Informant Mrs. Bertha Koehler
(b) Address 2933 Elliott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUN 26 1945 (b)
(Local Registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944, to June 23 1945, and that I last saw him alive on June 23 1945.

Immediate cause of death Marasmus Senilis — Duration

Due to

Due to

Other Conditions Chr. Cystitis, Chr. rectal fistula, Phymosis — Unknown
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. A. Rosenblatt, M. D.
Address 3618 O'Donnell St. Date signed 6-26-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30173 BALTIMORE CITY HEALTH DEPARTMENT G30173

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write in Rural and give town)
(d) Street No. 801 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hillary Mosley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-1900

8. AGE: Years 45 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Warren, Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Franks Mosley
13. Birthplace Va.

MOTHER 14. Maiden Name Nannie —
15. Birthplace Va.

16 (a) Informant Mrs. Daisy Mosley.
(b) Address 801 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St Washington Heights, Md

19 (a) Date received by registrar JUN 28 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 1040 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1945 to June 24 1945 and that I last saw alive on 19

Immediate cause of death Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 2 mos

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 74 [illegible] Date signed 6/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

G30174 V 290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G30174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3613 E.Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 E.Lombard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Suzan Schriver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Earnest Schriver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2-1862

8. AGE: Years	Months	Days	If less than one day
82	10	22	hr. min.

9. Birthplace Pa.
(City, town, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Conrad Spangler
13. Birthplace Pa.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mable Werner
(b) Address 3613 E.Lombard St.

17 (a) Burial (b) Date thereof June27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 3334 Jefferson St.

(Date rec'd by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1945 to 6/24 1945,
and that I last saw h[er] alive on 6/24 1945.

Immediate cause of death	Duration
(a) Cerebral Embolism	Three
Due to (b) Chronic Myocarditis	
Due to (c)	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ignatius A. Sydler
Address 3373 E. Balto St. Date signed 6/25/45

VS 150

G30175 Toth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G30175

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1534 E. Clement St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1534 E. Clement St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Toth.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3824

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katherine Toth.

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 26, 1892

8. AGE: Years 52 | Months 11 | Days 28 | If less than one day: hr min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation

11. Industry or business Grain trimmer

FATHER 12. Name Louis Toth

13. Birthplace Hungary

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Katherine Toth.

(b) Address 1534 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location Annapolis Blvd.

18 (a) Funeral director Jas. F. Dill.

(b) Address 1021 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b)

JUN 26 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20/ 1945, to 6/25/ 1945, and that I last saw h im alive on 6/23/ 1945.

Immediate cause of death: Bronchogenic carcinoma of lung — Duration: ?

Due to —

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Weibel M. D.

Address 1226 Hanover St. Date signed 6/26/ 1945

X

G30176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √136

G30176
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 W. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 W Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 - 30 - 1915

8. AGE: Years	Months	Days	If less than one day
30	0	24	hr. min.

9. Birthplace Bates, Md.
(town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Samuel M. Watkins
13. Birthplace Md.

MOTHER
14. Maiden Name Beta Connor
15. Birthplace Md.

16 (a) Informant Rita Watkins
(b) Address 216 W. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Rhandt Ave Huntington Station

19 (a) Huntington Station Registrar
(Date Received) JUN 26 1945

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 24 1945

G30177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 10417

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 S. Caroline Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 505 South Caroline St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA BELL CARROLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race negro | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Willie Anderson
13. Birthplace Virginia

MOTHER
14. Maiden Name Susie Anderson
15. Birthplace Virginia

16 (a) Informant Lovie May Hawkins
(b) Address 1509 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bsantley ave

19 (a) (Date received by registrar) June 26 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23/45 19 . at 9:05 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 6/27/45

VS 151

G30178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G30178 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly:

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 157 S. Monastery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 S. Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1879

8. AGE: Years 66 | Months 2 | Days 30 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Patrick McDonnell

13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah Welch

15. Birthplace Ireland

16 (a) Informant Cecelia T. Callahan

(b) Address 157 S. Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28-1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral City

Location Bath C. B. M. Walters

18 (a) Funeral director

(b) Address Pratt & Stricker Sts

19 (a) (Date received by registrar) (b) Registrar Huntington Williams M.D.

JUN 26 1945

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24th 1945, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 6/24 1945 and that I last saw h[illegible] alive on 6/23 1945.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G H Crawford M.D.

Address 4109 Second Ave Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution: St Agnes Hospital 28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County Reisterstown
(c) City or town Mt Hope Retreat (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John. M. Hines
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 11- 1891
8. AGE: Years 53 Months 7 Days 13 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Agnes Kelly
15. Birthplace Ireland

16 (a) Informant Mrs Theresa Hayes
(b) Address 1409 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Bolt Ct + B.M. Walter City
18 (a) Funeral director
(b) Address Pratt + Stricker St
19 (a) JUN 26 1945 (Date rec'd by Registrar) Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 24 1945 and that I last saw him alive on June 24 1945.

Immediate cause of death Acute Cardiac Failure — Duration

Due to Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6/22/45
Major findings of operation: Gangrene of right leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos A Alvarez M.D.
Address Huntington Ave Date signed 6/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30180
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6304 Widener Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Govanstown, Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6304 Widener Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda D. Pabst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Richard A.Pabst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/99

8. AGE: Years	Months	Days	If less than one day
46	5	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business At home

FATHER
12. Name Vitus Dicke
13. Birthplace Germany

MOTHER
14. Maiden Name Dorthy Michel
15. Birthplace Baltimore

16 (a) Informant Richard A. Pabst(husband)
(b) Address 6304 Widener Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.Wolfe St.

19 JUN 26 1945 (b) Huntington Williams, M.D.
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1944 to 6-23 1945, and that I last saw her alive on 6-21 1945

Immediate cause of death	Duration
CORONARY THROMBOSES	1½yrs
Due to CORONARY ARTERY DISEASE.	1½yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Garbza M. D.
Address 8217 York Rd Date signed 6/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1569

G30181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Hardy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Goldsmith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-97

8. AGE: Years 48 | Months - | Days 5 | If less than one day hr. min.

9. Birthplace Va (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Samuel Goldsmith
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Shandler
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof June 26-45 (month) (day) (year)
(c) Cemetery or crematory Norfolk, Va.
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (b)

JUN 26 1945

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1945 to June 26 1945 and that I last saw him alive on June 26 1945.

Immediate cause of death: Brain tumor — Duration

Due to — post operative

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/25/45

Major findings of operation: Pituitary adenoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben W. Crawford M.D.
Address Johns Hopkins Hosp Balto MD. Date signed 6/26/45

X

G30182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161C

Registered No. G30182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Diamond St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-45

8. AGE: Years 0 | Months 0 | Days 3 | If less than one day — hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Alonzo Jackson
13. Birthplace Bishopville S. Carolina

MOTHER
14. Maiden Name Rosabelle Byrd.
15. Birthplace Bishopville, S. Carolina

16 (a) Informant Mother
(b) Address 117 N. Diamond St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1945 at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1945 to 6-18 1945, and that I last saw her alive on 6-18 1945.

Immediate cause of death: Acute Heart Prostration
a Cerebral Hemorrhage. — Duration 10 hrs.
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6-17-45 at 5 P M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Univ Hosp. While at work? No
(Specify type of place)
(e) Means of injury Operating Room

23. Signature W. C. Eberling M.D.
Address Univ. Hosp. Date signed 6-18-45

181

VS 150

For P.C. Jelenko, by Howard J. Mueller, M.D.

G30183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30183 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Geo.
(c) City or town Bowie (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26, 1900

8. AGE: Years 45 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm. N. Moore
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Thomas
15. Birthplace Md.

16 (a) Informant Mrs. Mary Moore
(b) Address 1214 Florida Av. NE Wash. D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (month) (day) (year)
(c) Cemetery or crematory
Location Bowie, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) (b) Registrar

JUN 26 1945

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 1945, at 1 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1945, to 6/25 1945, and that I last saw him alive on 6/25 1945

Immediate cause of death Cardiac failure

Due to Luetic aortitis + valvular disease

Due to

Other Conditions Thrombophlebitis, left leg & gangrene L. foot (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Cardiac failure

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Otto R. Ewig, M.D.

Address Univ. Hosp. Balto., Md. Date signed 6/26/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G30184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

G30184 Registered No. 58932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mos. 16 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Everglades, (If outside city or town limits, write RURAL and give town)
(d) Street No. Lloyd House Fish Co. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME: Irving Charles Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1873

8. AGE: Years	Months	Days	If less than one day
72 yrs	2 mo	26days	hr. min.

9. Birthplace Tampa, Florida (Town, county, and state)
10. Usual Occupation 1st Mate
11. Industry or business Seafaring

FATHER
12. Name Frank Lowe
13. Birthplace Bahamas

MOTHER
14. Maiden Name Lenora Hart
15. Birthplace Tampa, Florida

16 (a) Informant Hospitals Record
(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-45 (month) (day) (year)
(c) Cemetery or crematory
Location St Petersburg - Fla -

18 (a) Funeral director L. Lee Adler
(b) Address 7644 York Rd.

JUN 26 1945

19 Filed Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945 at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1945 to June 23 1945, and that I last saw him alive on June 23 1945.

Immediate cause of death	Duration
Cachexia due to Carcinoma of the neck.	
Metastatic carcinoma of the	10 months
Due to cervical nodes, primary site unknown	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation 2/10/45	
Major findings of operation: Biopsy	
of autopsy: None done	1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin F. Jones M. D.
Address U. S. Marine Hospital Date signed 6/26/45

VS 150

Baltimore 11, Maryland.

G30185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G30185 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Tulsa
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verne C Dent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 - 1886

8. AGE: Years 59 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Kansas
(Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER
12. Name Martin Dent
13. Birthplace Ill.

MOTHER
14. Maiden Name Emma Chinenery
15. Birthplace Canada

16 (a) Informant Hosp. Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/26/45 (month) (day) (year)

(c) Cemetery or crematory
Location San Diego California

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

(b) Date of registration JUN 26 1945 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1945 at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6/24/45 5 P.M. 2/3

(b) Where did injury occur In front of 736 Thames St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Probable fall

23. Signature Robert Lee Fraser M.D.
Medical Examiner.

Date signed June 26 1945

G30186

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

G30186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 S. Angelsea St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 S. Angelsea St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS BAYARD MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie Miller
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Joseph M. Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Schraeder
15. Birthplace Germany

16 (a) Informant Mrs. Jennie Miller
(b) Address 411 S. Angelsea St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) JUN 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 5:47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1945. to June 24, 1945., and that I last saw h in alive on June 24, 1945.

Immediate cause of death Carcinoma of the stomach — Duration 2 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation February 17, 1945

Major findings of operation: Carcinoma of the stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Thor Artzman M. D.
Address 2942 E. Fayette St. Date signed 6/25/45

VS 150

G30187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G30187 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Sheffield Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 S Sheffield Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Adam Spann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sophia Spann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1866

8. AGE: Years 78 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Adam Spann
13. Birthplace Germany Md

MOTHER
14. Maiden Name Margaret Hofferbert
15. Birthplace Germany

16 (a) Informant Mrs Etta Bergendo
(b) Address 1518 S Sheffield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27-4 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

JUN 27 1945 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 1-a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1945 to June 24 1945 and that I last saw h[illegible] alive on June 25 1945.

Immediate cause of death: General Arteriosclerosis — Duration 1 year

Due to: Cerebral Arteriosclerosis

Due to:

Other Conditions: Cardiac Dilatation — 28 mos

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Cohen M.D.

Address 2015 E North Ave Date signed 6/27/45

97

G30188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30188 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Md.
(b) Street address
(c) Hospital or institution: 625 S. Montford Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julianna Lowinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-4993

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced? Married

6 (b) Name of husband or wife Casimir Lowinski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1890

8. AGE: Years 54 | Months 6 | Days | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Bigtrowski

13. Birthplace Poland

MOTHER 14. Maiden Name Salomia Kielczyk

15. Birthplace Poland

16 (a) Informant Casimir Lowinski

(b) Address 625 S. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. Ozog

(b) Address 1930 Eastern Ave

JUN 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1945, at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed June 25, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47D

G30189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 S. Macon st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Macon st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maud A. McQueen

3 (b) If veteran, name war: NU
3 (c) Social Security Account No. 24-03-2198

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Annie M. McQueen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2nd 1880

8. AGE: Years	Months	Days	If less than one day
65	5	23	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Md. Dry Dock

FATHER
12. Name Neill McQueen
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Stewart
15. Birthplace "

16 (a) Informant Annie M. McQueen
(b) Address 329 S. Macon st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)
(c) Cemetery or crematory Oakland Cem
Location Balto. Md.

18 (a) Funeral director William Fox Inc.
(b) Address 127 St. Paul St.

19 (a) Date received (month) (day) (year) JUN 27 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th 1945, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2- 1945, to 6-25 1945; and that I last saw him alive on 6-23- 1945.

Immediate cause of death: Carcinoma of rt. lung — Duration: 7 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury M. J. Dandow
23. Signature M. J. Dandow M. D.
Address 3218 Eastern ave Date signed 6-27-45

X

G.30190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

✓ G.30190 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Bonaparte Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Bonaparte Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Kerns

3 (b) If veteran, name war

3 (c) Social Security Account No. 243-05-7673

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Edna May Kerns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24th 1886

8. AGE: Years	Months	Days	If less than one day
59	3	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Glen F. Martin

FATHER
12. Name Kerns
13. Birthplace Md

MOTHER
14. Maiden Name Laura May ?
15. Birthplace Md.

16 (a) Informant Edna May Kerns
(b) Address 1112 Bonaparte Ave

17 (a) Burial (b) Date thereof 6/30/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) JUN 27 1945 (b)
(Date received by registrar) Huntington Ave, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26th 1945, at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6. 12. 1944 to 6. 26. 1945, and that I last saw h— alive on 6. 25. 1945.

Immediate cause of death
Carcenoma Stomach — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Kagan M.D. Address 1761 E Mon Ave Date signed 6/26/45

Samuel Kagan

G30194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G30194 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 St. Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary G. Lattin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband Edward E. Lattin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22nd 1879

8. AGE: Years 65 66 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Unknown) Harding
13. Birthplace md.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs L. M. Shuler
(b) Address 811 E. 22nd St.

17 (a) Burial (b) Date thereof 6/28/45
(Burial, ~~cremation or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Signature for William M.B. Registrar

JUN 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th 1945, at 11 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1945 to June 25 1945, and that I last saw h[er] alive on June 3 1945.

Immediate cause of death Carcinoma Liver — Duration 1 yr

Due to

Due to

Other Conditions Myocardites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest H. Rahn M. D.
Address 735 Poplar St Date signed 6/26/45

X

G30192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G30192 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 N. Chapel St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race Black

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-44.

8. AGE: Years | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jerum Banks.

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Hamilton

15. Birthplace N.C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem. Location Q.A. County Md.

18 (a) Funeral director Mrs Robert A. Ellis Sr.

(b) Address 1291 N. Caroline St.

JUN 27 1945 (a) Date rec'd by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945, to 6-24 1945, and that I last saw h-- alive on 6-24 1945.

Immediate cause of death: Intussusception of small Bowel. — Duration: 1 day.

Due to: Bath following surgery

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work?)

(e) Means of injury

23. Signature Evan H. Daniel M. D.

Address JHH Date signed 6-25-45

VS 150

Dr Daniel X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

b 30193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 D

G30193
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Sarah Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Johnson Doton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2. 1894

8. AGE: Years	Months	Days	If less than one day
51	4	19	hr. min.

9. Birthplace Crewe, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace Va.

16 (a) Informant Ola Reid Ford.
(b) Address 223 N Carrollton Ave

17 (a) Burial (b) Date thereof 6-27-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kathryn R Williams
(b) Address 322 N Schroeder St.

19 (a) JUN 27 1945 Huntingtown Williams, Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 8 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy & dilatation

Due to Syphilitic aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D.
Medical Examiner.
Date signed June 21 1945

G30194
474/65.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 309

G30194
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER ALLEN BRUCHEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-10-0810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	separated

6 (b) Name of husband or wife Dorothy V. Bruchey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-91

8. AGE: Years	Months	Days	If less than one day
53	10	25	hr. min.

9. Birthplace Frederick Md
(Town, county, and state)
10. Usual Occupation Handy. man.
11. Industry or business Uptown Nite Club

FATHER
12. Name William Bruchey.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary S.
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 6/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

19 (a) (b) Huntington Williams, M.D.
(Signature of local registrar)

JUN 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1945 at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1945 to June 26 1945 and that I last saw him alive on June 26 1945.

Immediate cause of death Miliary tuberculosis — Duration 6 wks.
Due to
Due to
Other Conditions Extra pulmonary syphilis Chronic alcoholism
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Graham C. Vance M.D.
Address Johns Hopkins Hospital Date signed 6/26/45

13B

630193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

630193 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address V.A.R.
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2565 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Culotta

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Viola Culotta
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 4, 1896
8. AGE: Years: 49 | Months: 3 | Days: 21 | If less than one day: hr. min.
9. Birthplace: Phila., Pa. (Town, county, and state)
10. Usual Occupation: Iron Worker
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Viola Culotta
(b) Address: 2565 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) JUN 27 1945 (b) [illegible] Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 1945, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G30196

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Wilmington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Leach.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/24/45

8. AGE: Years	Months	Days	If less than one day
			1 hr. 58 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie
13. Birthplace

MOTHER
14. Maiden Name Virginia
15. Birthplace Md.

16 (a) Informant Hospital Record
(b) Address Caton & Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Bailey & Sons
(b) Address 1827 N. North Ave.

19 (a) (Signature) Huntington Williams, M.D.

JUN 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1945, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1945 to 6/24 1945, and that I last saw her alive on ~~6/25~~ 6/24 1945.

Immediate cause of death	Duration
Pulmonary atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jose Alvarez de Chondens M. D.
Address St. Agnes Hospital Date signed 6/25/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G30197

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6014 Sycamore Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/45

8. AGE: Years | Months | Days | If less than one day: 17 hr. 5 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lawrence

13. Birthplace

MOTHER 14. Maiden Name Alberta Cole

15. Birthplace Maryland.

16 (a) Informant Hospital Rec'd

(b) Address Caton & Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Fahy & Sons

(b) Address 1827 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26 19 45 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 19 45 to 6/26 19 45

and that I last saw h/as alive on 6/26 19 45

Immediate cause of death: Pulmonary atelectasis

Due to: Prematurity

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jose A Alvarez de Arcaute M. D.

Address St Agnes Hospital Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121

630198 Registered No.

1. PLACE OF DEATH: St Agnes Hospital
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St Agnes Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Lyndhurst St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jeanette M. Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Husband - John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-08

8. AGE: Years	Months	Days	If less than one day
36	11	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris Knight (dec.)
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Schaffer
15. Birthplace Md.

16 (a) Informant John H. Kaufmann
(b) Address 813 Lyndhurst St.

17 (a) Burial (b) Date thereof 6-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Martin Zahn & Sons
(b) Address 1827 W. North Ave.

19 (a) (b)
(Date received by registrar) JUN 27 1945 Huntington Williams, M.D. Registrar

VS 150

20. DATE OF DEATH June 24 1945 at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 1945, to 6-24 1945, and that I last saw h[illegible] alive on 6-24-45

Immediate cause of death	Duration
Acute cardiac failure	
Due to Generalized Peritonitis	
Due to Perforated Appendix	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm B Alvary Jr Chandler M. D.

Address [illegible] Date signed

X

G30199 BALTIMORE CITY HEALTH DEPARTMENT G30199

CERTIFICATE OF DEATH 48B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE LOSCHER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife PHILIP
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name MOSES GUTKIN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name RACHAEL
15. Birthplace RUSSIA

16 (a) Informant LEE LOSCHER
(b) Address 1716 ROXTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHILA RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date rec'd by r...) (b) Huntington Williamson

VS-10

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26-45 19 ..., at 9 10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/15 1943 to 6-26-45, and that I last saw h... alive on 6-26 1945.

Immediate cause of death Carcinomatosis — Duration

Due to Pelvic organs — 18m

Due to — over

Other Conditions Terminal Bronchopneumonia — 2dy

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W J Baylin

Address 2040 Eutaw Date signed 6/29/45

X

G30200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58B

Registered No. G30200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christina Coleman (Davis)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1911

8. AGE: Years	Months	Days	If less than one day
33	8	23	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Eli, Chatman
13. Birthplace ?

MOTHER
14. Maiden Name Mazurie
15. Birthplace ?

16 (a) Informant Mrs. McKinsey
(b) Address 1019 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-45 (month) (day) (year)
(c) Cemetery or crematory Spartanburg
Location South Carolina

18 (a) Funeral director Adolphus Haliste
(b) Address 918 Druid Hill Ave

19 JUN 27 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 45 19 8 A. at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Rheumatic Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 23, 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G30201

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 315 W. Hoffman St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sallie Smith

3 (b) If veteran, name war

~~3 (c) Social~~ Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife Henry Smith.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/21/1865

8. AGE: Years	Months	Days	If less than one day
79	10	3	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name ? Ryan

13. Birthplace Balto

MOTHER

14. Maiden Name ?

15. Birthplace

16 (a) Informant Hospital Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27, 1945 (month) (day) (year)

(c) Cemetery or crematory Cybutler Mem. Pk

Location Baltimore Co. Md.

18 (a) Funeral director James A. Hollins

(b) Address 1481 Pennsylvania Ave

19 (a) (b) Huntington Wilkinson

(Date rec'd by registrar) JUN 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 19 45 at 2.26 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 19 45 to 6/24 19 45 and that I last saw he alive on 6/24 19 45

Immediate cause of death Uremia Lage — Duration ?

Due to Probable malignancy of GI tract

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Earl W. Putnam M.D. M. D.

Address Date signed

X

G30202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G30202
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 McHenry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie A. Lukenich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Gabriel Lukenich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1891.

8. AGE: Years 54 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Traugot Lange
13. Birthplace Germany

MOTHER
14. Maiden Name Coolidge
15. Birthplace Germany

16 (a) Informant Susan Lukenich
(b) Address 1400 McHenry St.

17 (a) Burial (b) Date thereof June 29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Witzke,
(b) Address 4101 Edmondson Ave.

19 (a) JUN 27 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26 1945 at 5:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1945 to 6/26 1945.
and that I last saw her alive on 6/22 1945

	Duration
Immediate cause of death: 1 hypertensive cardio vascular disease	2 yrs
Due to	
Due to	
Other Conditions: Cerebral hemorrhage (Include pregnancy within 3 months of death)	12 hrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens Ave Date signed 6/27/45

Huntington Williams, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G30203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113

G30203
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N Eastern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Foster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1873

8. AGE: Years 72 | Months | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Car Repairs

FATHER 12. Name John Foster

13. Birthplace

MOTHER 14. Maiden Name Maria Hester

15. Birthplace

16 (a) Informant Mary Foster

(b) Address 519 E Eat Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Jackson Coffin

(b) Address 1717 Huntington Ave

JUN 27 1945 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945, at 6:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/45 19 to 6/27/45, and that I last saw h[illegible] alive on 6/26/45 19.

Immediate cause of death Cardiac Dilatation — Duration 3 days.

Due to Pulmonary Tuberculosis — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Herrman M. D.
Address 1710 E 32nd St Date signed 6/27/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 N Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 N Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alma Bond Pelot

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Hugh Pelot
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	5	hr. min.

9. Birthplace Wilton Co Ga
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Woodson Hudson
13. Birthplace Walton Co Ga

MOTHER
14. Maiden Name Susan Gunter
15. Birthplace Walton Co Ga

16 (a) Informant Hugh Pelot
(b) Address 1318 N Kenwood Ave

17 (a) Removal (b) Date thereof 6-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Hudson Lecompte
(b) Address 2417 E Monument

19 (a) JUN 27 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945, at 6:42 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to June 27 1945 and that I last saw her alive on June 21 1945

Immediate cause of death Acute Cardiac Failure — Duration 10 min.
Due to Cancer of descending colon — Duration 1 year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Israel Rosen M. D.
Address 2413 E Monument St Date signed

X 6/27/45

Dr Davies
Cert G30605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G30605

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2064 Pochonee ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2064 Pochonee ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Esby.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Johanna F. Esby

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov 9 1863

8. AGE: Years 81 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Mt. Vernon Mills.

FATHER
12. Name Wm. Esby.
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Parsons
15. Birthplace Maryland

16 (a) Informant Johanna F. Esby.
(b) Address 2064 Pochonee ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Thanhouser & Sonnaer
(b) Address 3615-17 Clifton Ave

19 (a) (b)
JUN 27 1945 Filed by registrar Arlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to June 23 1945, and that I last saw him alive on June 23 1945.

Immediate cause of death: Myocardial Insufficiency — Duration 1 day
Due to Arteriosclerosis — 20 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 8004 33rd St Date signed 6-26-45

G30-06

Laurel #9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30-06

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
Street No. 1500 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JUN 25 1945
18 (a) Funeral director Commissioner of Health
(b) Address
JUN 27 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1945, at 6:35 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereof and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 6/12/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30207 G30207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 E. Heath Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 E. Heath Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fraley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John A. Fraley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ---------
15. Birthplace Ireland

16 (a) Informant Edward J. Fraley
(b) Address 1540 Light Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St,

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 27 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1945, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7, 1945, to June 25 1945, and that I last saw alive on Jan 20 1945.

Immediate cause of death Acute Dilatation of heart — Duration 3 Ds.

Due to Mitral Regurgitation — Duration Indef.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. R. Campbell M. D.
Address 1644 Harlem Date signed 6/27/45

G30208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30208

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparks
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rmte 10.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley McCall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1944

8. AGE: Years 1 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Sparks, Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Laurence McCall
13. Birthplace South Carolina Jenkins

MOTHER
14. Maiden Name Ethel McCall
15. Birthplace Sparks, Balto Co, Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof June 29 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stephenson Chapel
Location Sparks, Md

18 (a) Funeral director Landon M. Bevins
(b) Address Sparks, Md

19 6-27-1945 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1945 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Dead on arrival — Duration:

Due to: Pertussis - Asphyxia — 1 month

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis W. Neffrich M. D.

Address JHH Date signed 6-27-45

Leland C. Gratiot M.D.

G30209

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 ✓

G30209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 S. Green St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Green St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife William Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Montera Mar Sell
(b) Address 510 S. Green St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6 28 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary Cemtery
Location Balto.

18 (a) Funeral director Walter B. Spigg
(b) Address 139 W. Hamburg St.

19 (a) JUN 28 1945 (b) Huntington & Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to June 24 1945, and that I last saw her alive on June 25 1945.

Immediate cause of death — Duration

Valvular Heart Disease

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M.D.
Address 1631 W Hamblin St Date signed 9/27/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G30210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Hyattsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 Longfellow St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Adelaide M. Erwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or ~~wife~~ Edward J. Erwin, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	2	hr. min.

9. Birthplace New York, N.Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Demuth
13. Birthplace New Jersey

MOTHER
14. Maiden Name Margaret Wolf
15. Birthplace New York N.Y.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. - Balto

17 (a) Removal (b) Date thereof 6/27/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Riverdale
Location Md.

18 (a) Funeral director W. W. Chambers Co
(b) Address Washington D.C.

JUN 28 1945 (Registered by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945, at 3:32 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 26 1945 to June 27 1945, and that I last saw h[illegible] alive on June 27 1945.

Immediate cause of death: Coronary Occlusion — Duration: 1 day
Due to: Colostomy for ~~Rectal~~ arteriosclerosis — 12 Wks
Due to:
Other Conditions: Involutional Melancholia — 7 mos.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D Palagia M. D.
Address 336 Cathedral St. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a City Registered No. 30211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2de
(e) Length of stay in Baltimore (yrs., mos., or days) 2de

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Eutaw Town Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Card (CARD)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/19/45
8. AGE: Years | Months | Days 2 | If less than one day hr. min.
9. Birthplace 619 Eutaw Town Rd (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown to informant
13. Birthplace

MOTHER
14. Maiden Name Lillian Marie Card
15. Birthplace

16 (a) Informant Aunt
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 28 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 19 45 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 19 45 to 6/21 19 45 and that I last saw h. alive on 6/21 19 45

Immediate cause of death Resp Failure — Duration

Due to Extra-Cranial birth Hemorrhage — 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nil

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw H Woodbury Jr. M.D.
Address Univ Hosp Date signed 6/21/45

12787

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Re-30212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

S-30212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Division St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Agent no II

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-27-45

8. AGE: Years	Months	Days	If less than one day
	1		hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William M. Carter
13. Birthplace Md

MOTHER
14. Maiden Name Helena Agent
15. Birthplace Va.

16 (a) Informant Helena Agent
(b) Address 1125 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or [illegible] CEMETERY JUL 6 1945
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 7 1945 Hunter Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1945, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27-1945 to 6-25-1945, and that I last saw h[illegible] alive on 6-25-1945.

Immediate cause of death	Duration
Atelectasis	
Prematurity - 1mo	
Due to Twin	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Louise Young M.D.

Address 1100 Druid Hill Ave Date signed 7-2-45

G30213

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G30213

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cross ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
69	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant William Cross
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 28 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1945 to 6/17 1945. and that I last saw him alive on 6/17 1945.

Immediate cause of death Respiratory failure — Duration

Due to ~~Arteriosclerosis~~ Pneumonia — two days

Due to Arteriosclerotic C.V.D. — chronic

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas D. Chaplin
Address University Hospital Date signed 6/17/45

VS 150

T2-88

G30214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G30214

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4012 Frankford Ave
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 4 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltolcity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Frankford Ave (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Helen Gontrum

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jno. F. Gontrum
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 1 1866

8. AGE: Years 79 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Thos. C. Biddison
13. Birthplace Balto Co

MOTHER
14. Maiden Name Julia Mac Paulay
15. Birthplace Q A Co. Md

16 (a) Informant John B. Gontrum (son)
(b) Address Glen Arm - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Sherwood Morgan Co
(b) Address 108 W North Ave.

19 JUN 28 1945 (Date received by city registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 45 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 19 .. to 6-26 19 45 and that I last saw h[illegible] alive on 12 30 PM 19 6-26

Immediate cause of death: Pneumonia & Dec — Duration 10 dys
Due to: — Due to Chr myocarditis — 20 yrs
Other Conditions: Diabetes Mellitus — 20 yrs
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Hospod M. D.
Address 200 W Lafayette Ave Date signed 6/27/45

925

VS 150

G30215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G30215

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E. Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? ~~Yes~~ or No
If yes, name country —

3 (a) FULL NAME Mrs. Emanuel L. Oster (Mary) MARY-ANNA-OSTER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Emanuel L. Oster

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July-15-1875

8. AGE: Years 69 | Months 11 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Schaub
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Seele
15. Birthplace Germany

16 (a) Informant Mr. Henry Oster (Son)
(b) Address 2627 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. WOODEN SUC.) 108 W. NORTH AVENUE
(b) Address

19 JUN 28 1945 Huntington Williams M.D.
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1945, to 6/27 1945, and that I last saw her alive on 6/27 1945.

Immediate cause of death Cardiac failure
Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions Obstetrical abstraction due to inflammatory adhesions
(Include pregnancy within 3 months of death)

Date of operation 6/26/45

Major findings of operation: Multiple fibromyomata uteri & adhesions involving ~~stomach~~ bowel & omentum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee M.D.

Address Union Memorial Hospital Date signed 6/27/45

G30216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G30216

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St Josephs Hosp. 2 1/2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Da

(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md County Balto.

(c) City or (give town) BALTIMORE

(d) Street 1003 SOUTH EAST Ave

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Josephine Crispens

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CASPER CRISPENS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 3 1890

8. AGE: Years 55 | Months 2 | Days 24 | If less than one day: hr. min.

9. Birthplace NEW YORK (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER

12. Name EDWARD RUSSELOW

13. Birthplace FRANCE

MOTHER

14. Maiden Name UNKNOWN

15. Birthplace FRANCE

16 (a) Informant CASPER CRISPENS (HUS)

(b) Address 1003 S.EAST AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 30/45 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Geiler Sons

(b) Address S.WOLFE ST.

JUN 28 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27- 1945 at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7 1945 to 6-27 1945.

and that I last saw her alive on 6-27 1945.

Immediate cause of death: Respiratory Failure

Due to: Carcinoma Ft. Lung

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes: General; 2ed Carcinoma

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M.E. Robertson M. D.

Address St. Josephs Hosp Date signed 6-27-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G30217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 Bonaparte Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Parley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET (MAGGIE) WILHELMINA SPURRY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Thomas Spurry
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1860

8. AGE: Years: 84 | Months: 7 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Frederick Kraft
13. Birthplace: Germany

MOTHER
14. Maiden Name: Eleanor Schubert
15. Birthplace: Virginia

16 (a) Informant: Mr. Frederick L. Dauser
(b) Address: 1020 Bonaparte Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SNADER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 28 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH June 23 1945 at 3.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to June 26 1945 and that I last saw her alive on June 25 1945.

Immediate cause of death: Cerebral Embolism — Respiratory Failure — Duration: 30 hrs
Due to: Malignancy Left Breast — 2 yrs
Due to: Arterio-Sclerosis — High Blood Pressure — 5 yrs
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Fred J. Thompson M.D.
Address: 9858 Halford Rd. Date signed 6/26/45

G30218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30218 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address RAYNER + DOKELAND AV.

(c) Hospital or institution: WEST BALT. GEN. HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days 37 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 2602 Boarman (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME JACOB GEARE

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Paper hanger

11. Industry or business

FATHER 12. Name Hyman

13. Birthplace Russia

MOTHER 14. Maiden Name Rebecca

15. Birthplace Russia

16 (a) Informant Husb. Resade

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Pulaski Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E Baltimore St.

19 (a) JUN 28 1945 (Date received by Local Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 1945, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27 1945 to 6/27 1945 and that I last saw h alive on 6/27 1945.

Immediate cause of death ACUTE CORONARY THROMBOSIS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. Silverfeld M. D.

Address West Balt. Gen. Hosp. Date signed 6/27/45

VS 150

G30219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairfield Shipyards
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Ridgewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry M. Ritzberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY

8. AGE: Years	Months	Days	If less than one day
43 45			hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Traveling Salesman

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Rona
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-45 (month) (day) (year)
(c) Cemetery or crematory Wash Rd
Location Wash Rd.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1437 E. Balto St.

19 (a) JUN 28 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945 at 10 30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed June 27 1945

G30220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 777

Registered No. G30220

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a). FULL NAME William B. Roe

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-22-4959

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Myra Roe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67	4	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name James W. Roe
13. Birthplace Md.

MOTHER
14. Maiden Name Mathilda Handcock
15. Birthplace Md

16 (a) Informant Susie Gardner
(b) Address 1238 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28th 1945 (Month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill.
(b) Address 1502 Fort Ave.

19 JUN 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1945, at 4:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D. (Medical Examiner)

Date signed June 27 1945

G30224 — Ward 13 Room 1206 Register 27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. _____

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gloinie C. McCullough

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1874

8. AGE: Years	Months	Days	If less than one day
70	11	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Charles A. Curtis
13. Birthplace Md

MOTHER'S
14. Maiden Name Sarah Lewis
15. Birthplace Md

16 (a) Informant Edna L. McCullough
(b) Address 210 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Milburn Lodge
(b) Address 1219 N. Fulton Ave

19 (a) Date rec'd by registrar JUN 28 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1945, at 9:52 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 6/26 1945, and that I last saw h Dr alive on 6/24 1945.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden
Due to: Chronic Arteriosclerotic Cardio-Vascular Disease — Duration: ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Blum
Address 1206 E. Preston St. Date signed 6/27/45

G30222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hanford Rd. & Herring Run.

(c) Hospital or institution: Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 9 Da

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Fort Howard
(If outside city or town limits, write RURAL and give town)

(d) Street No. Todd's Farm
(If rural give location)

(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Bitter, Mary Elizabeth

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/33 1934

8. AGE: Years	Months	Days	If less than one day
12	5	3	hr. min.

9. Birthplace June Arundel County, Md.
(Town, county, and state)

10. Usual Occupation school

11. Industry or business

FATHER

12. Name George S. Bitter

13. Birthplace Baltimore - Md.

MOTHER

14. Maiden Name Mathilda Kooge

15. Birthplace Davenport, Iowa

16 (a) Informant George S. Bitter

(b) Address Fort Howard, Md.

17 (a) Burial (b) Date thereof June 30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery

Location 4900 Belair Rd

18 (a) Funeral director Edgar W. Coppling & Son

(b) Address 924 E. Eager St.

19 (a) JUN 28 1945 (b) Huntington Williams, M.D.

VS 3

(over)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...,
and that I last saw h... alive on ..... 19....

Immediate cause of death	Duration
Circulatory collapse	
Due to Meningococcemia (Waterhouse - Friderichsen syndrome)	24 hrs.
Due to Meningococcal meningitis	24 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Bilateral adrenal Hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret N. D. Smith M. D.

Address Sydenham Date signed 6-27

Approved Robert Lee Graham, M.D. 6/28/45 – X

G30223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G30223 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Tabastus Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Johanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1878

8. AGE: Years 47 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Charles Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Turner
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-45 (month) (day) (year)
(c) Cemetery or crematory St Stephens
Location St Stephens, Elkridge Md

18 (a) Funeral director F C Negus & Brothers
(b) Address Ellicott City Md

19 JUN 28 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945 at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to June 25 1945 and that I last saw h alive on June 25 1945

Immediate cause of death T.B. Meningitis

Duration 2 wks

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glen R Leymaster

Address Johns Hopkins Hosp Date signed 6/25/45 M. D.

VS 150

G30224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30224

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 E. 23rd St.
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE B. SCHWARTZ

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.: married

6 (b) Name of husband or wife: George F. Schwartz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1882

8. AGE: Years	Months	Days	If less than one day
62	7	0	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Dowell
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Byrn
15. Birthplace Md.

16 (a) Informant Mr. Milton B. Schorr, son-in-law
(b) Address 2907 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 28 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to JUN 27 1945.
and that I last saw h her alive on Jun 27 1945.

Immediate cause of death: Cardio-Vascular Renal — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J. Kinzer M. D.
Address 2700 Harford Rd Date signed 6/28/45

X Kinzer

G30225

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4032 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4032 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARETTA MARGARET HIDEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Hidey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1853

8. AGE: Years	Months	Days	If less than one day
92	3	20	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Mass.

MOTHER
14. Maiden Name Ruth Bennett
15. Birthplace Balto. Co., Md.

16 (a) Informant Miss Olive Hidey
(b) Address 4032 Hayward Ave.

17 (a) Burial (b) Date thereof 6/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 28 1945 (b) Huntington Williams M.D.
(Registrar's signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to June 27 1945, and that I last saw her alive on June 25 1945.

Immediate cause of death Myocarditis
Due to Arteriosclerosis
Due to Senility
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Breen M. D.
Address 5276 Park Heights Av Date signed June 28 45

VS 150

G30226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G30226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Calhoun st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 N
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Calhoun st (If rural give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

3 (a) FULL NAME Doris H Carroll.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-23-1931

8. AGE: Years	Months	Days	If less than one day
14	3	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Ernest Jones
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Horshaw
15. Birthplace Md

16 (a) Informant Catherine Carroll
(b) Address 914 Calhoun st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30 45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus Md

18 (a) Funeral director Wallace A Jackson
(b) Address 916 Pennsylvania ave
(c) Date received by registrar JUN 28 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th 1945, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945, to June 27 1945, and that I last saw her alive on June 27 1945.

Immediate cause of death Acute Myocarditis — Duration 1 month

Due to unknown

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Conrad Bode M. D.

Address 1900 Maryland Ave Date signed 6-27-45

G30227 AB-94389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30227 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs ½
(e) Length of stay in Baltimore (yrs., mos., or days) Life W.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Bouldin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Staigerwald (JOHN W. STAIGERWALD)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7817

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22- 1892

8. AGE: Years	Months	Days	If less than one day
53	1	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Haring Sons
(b) Address 2024 Orleans St.

19 JUN 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26- 1945, at 9.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26- 1945, to 6-26- 1945., and that I last saw him alive on 6-26- 1945.

Immediate cause of death	Duration
Cardiac insufficiency Shock	
Due to Coronary occlusion due to arteriosclerotic	4 hrs
Due to coronary disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 6-27-45

VS 150

G30228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30228 Registered No. 3698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Crumblore

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932. N. Strieker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 932. N. Strieker (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Dan'l F. Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25-1895

8. AGE: Years 49 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace St Mary's Co
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Trumblons. Garner md

13. Birthplace

MOTHER 14. Maiden Name Nethe millard md

15. Birthplace

16 (a) Informant Mary E. Claiborne

(b) Address 1511 Presson Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (month) (day) (year)

(c) Cemetery or crematory St Joseph's

Location St Mary's Co md

18 (a) Funeral director Sam'l F. Chase Hm

(b) Address 638 N. Gilmor St

19 (Signature and title) Huntington Williams, M.D.

JUN 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27- 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15- 1945, to 6-27- 1945, and that I last saw h[illegible] alive on 6-27- 1945.

Immediate cause of death Myocarditis

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank P. Saunders M. D.

Address 1029 N. Strieker Date signed 6-28-45

X

G30229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G30229
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E. Chase St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA LEIGHTNER (LEIDNER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jacob Leightner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
82	11		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Michael Gaegner
13. Birthplace Germany

MOTHER
14. Maiden Name Don&t know
15. Birthplace Germany

16 (a) Informant Mrs. Barbara Starr
(b) Address 2021 E. Chase St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

(c) JUN 28 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to June 25 1945 and that I last saw h[illegible] alive on June 23 1945.

Immediate cause of death: Chronic nephritis arteriosclerosis — Duration: ?
Due to
Due to
Other Conditions Myocardial insufficiency — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Timmes M.D.
Address 2623 E. Monument Date signed 6/27/45

VS 150

G30230

G30230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 927
(b) Street address 927 W Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 W Mulberry (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jessamine Dodd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife Wiebur Dodd.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21-1921

8. AGE: Years 24 yr | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Raleigh, N.C. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Arthur Jones
13. Birthplace Raleigh N.C.

MOTHER
14. Maiden Name Zenobia Hunter
15. Birthplace Raleigh, N.C.

16 (a) Informant Helen Lancaster
(b) Address 939 W Mulberry St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)

(c) Cemetery or crematory
Location Raleigh, N.C.

18 (a) Funeral director Mrs Tate R. Williams
(b) Address 322 N. Saharoden St.
Huntington Williams Mortuary

JUN 28 1945 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1945 at 1140 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1945 to June 26 1945 and that I last saw h er alive on June 25 1945.

Immediate cause of death

Due to Broncho pneumonia and Bronchial Asthma — Duration: 1 wk

Due to — Duration: 5 yr.

Other Conditions Myxandtis — Duration: (?)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Jos D Julian Jr

Address 511 N Salisbury St Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55D

G30231
Registered No. 57635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL, and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME: Ling, Chang Pon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Yellow	Married

6 (b) Name of husband or wife Wong Ling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1901

8. AGE: Years	Months	Days	If less than one day
44	1	14	hr. min.

9. Birthplace Shanghai, China (Town, county, and state)
10. Usual Occupation SEAMAN
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace CHINA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace CHINA

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-28-45 (month) (day) (year)
(c) Cemetery or crematory New York City
Location Jack Lewis Inc
18 (a) Funeral director
(b) Address 1439 E. Baltd
19 (a) JUN 28 1945 (b) Registrar Huntington Hillcrest, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1945, at 12:30 A. M. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1944, to June 26 1945 and that I last saw him alive on June 26 1945

Immediate cause of death Purulent meningitis — Duration 10 days

Due to Cancer of the right antrum with extension into the base of the brain — Duration 1 year

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin D. Jones, M.D.
Address U. S. Marine Hospital, Baltimore 11, Maryland. Date signed 6/28/45

G30232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G30232
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2607 Orleans St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Chase (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ivy Virginia Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wilbur E. Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2 1915

8. AGE: Years 29 | Months 9 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph H. Hudson
13. Birthplace Ireland

MOTHER
14. Maiden Name Ida Hinkle
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Thelma Fishpaw
(b) Address Timonium, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June (month) (day) (year)
(c) Cemetery or crematory Providence
Location Providence, Baltimore Co. Md.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Hall Towson, Md. Registrar

VS JUN 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1945, at 1120 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1945 to 6-26 1945
and that I last saw h[illegible] alive on 6-25-45

	Duration
Immediate cause of death: Pneumonia (Primary)	7 days
Due to: Influenza	
Due to: Acute Anemia	
Other conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 701 Mathieson Bldg Date signed 6-27-45

G30233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30233 Registered No. 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Warner Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Witherspoon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1925

8. AGE: Years 19 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Stage Building
11. Industry or business

FATHER
12. Name Wyston Witherspoon
13. Birthplace Sumter S. C.

MOTHER
14. Maiden Name Lela Brown
15. Birthplace Sumter S. C.

16 (a) Informant Lela Witherspoon
(b) Address Branch St. S. C.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6 30 46 (month) (day) (year)
(c) Cemetery or crematory Sumter S. C.
Location

18 (a) Funeral director
(b) Address

19 (a) (Date received by Registrar) JUN 28 1945 (b) Huntington Williams, M.D. Registrar

150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1945, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1945 to 6-27 1945 and that I last saw h Im alive on 6-27 1945.

Immediate cause of death (a) 1st, 2nd 3rd degree burns arms legs, trunk face
Due to 1070
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/6 p
(a) Accident, suicide, or homicide acc
(b) Date of occurrence June 25, 1945 at 5:15 M
(c) Where did injury occur? No. Dak. Ter. Dey Dak Co. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial (Specify type of place) While at work? Yes
(e) Means of injury Gasoline tank exploded

23. Signature D Dharon M. D.
Address Univ Hosp Date signed 6-27-45

for B.H. Belt McNally, by Howard J. Malden, M.D.

Canare #10

G30234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

Registered No. G30234

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. ? Found: 100 Blk W. Balto St.
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Unknown

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. .....

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years 38? Months ..... Days ..... If less than one day ..... hr. ..... min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business .....

FATHER
12. Name ?
13. Birthplace .....

MOTHER
14. Maiden Name ?
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....
Location PUBLIC CEMETERY JUN 28 1945

18 (a) Funeral director Commissioner of Health

(b) Address .....

19 (a) JUN 28 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Leptomeningitis

.....

Due to .....

.....

Other Conditions .....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature Howard J. Malpas M.D.
Medical Examiner.

Date signed 6-28-45 per Robert Lee Eustace ?

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30235 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 E. Eager Street
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 E. Eager Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Metz

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary C. Simon
6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb. 23rd, 1862

8. AGE: Years	Months	Days	If less than one day
83	4	2	##### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired-Clothing Cutter
11. Industry or business

FATHER
12. Name: John Metz
13. Birthplace: Germany

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. Mary C. Metz (Wife)
(b) Address: 1310 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) JUN 28 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th, 1945 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1943, to June 25 1945, and that I last saw h[illegible] alive on Jan 6 1945.

Immediate cause of death	Duration
Senility	
Arteriosclerosis	1943
Due to Myocarditis	1943
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Krahmer M. D.
Address 350 S. Dartmouth Date signed 6/27/45

VS 150

G30236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G30236
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Savage
(If outside city or town limits write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Jones
13. Birthplace

MOTHER
14. Maiden Name Wilma Nolan
15. Birthplace Conn.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 2 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 JUN 28 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1945 to 6/19 1945 and that I last saw her alive on 6/19 1945.

Immediate cause of death	Duration
Prematurity, early	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mueller M. D.
Address Univ Hosp Date signed 6/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

2792

G30237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30237 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp 22

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. Md Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Daniels

3 (b) If veteran, name war	3 (c) Social Security Account No.
/	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		/	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniels
13. Birthplace ? Jamaica

MOTHER
14. Maiden Name Jones
15. Birthplace ? Jamaica

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 28 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945 to 6/10 1945.
and that I last saw h.. alive on 6/10 1945.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert T Mark M. D.
Address Univ Hosp Date signed 6/12

VS 150

F 2793

G30238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G30238
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 Ward St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnie E Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Marvin Covell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1901

8. AGE: Years 44 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation Factory Hand

11. Industry or business Ed M. Cigars

FATHER
12. Name John E Thomas
13. Birthplace St. Mary's Co Md

MOTHER
14. Maiden Name Grace L. Yeatt
15. Birthplace Calvert Co Md

16 (a) Informant William E Thomas
(b) Address 1142 Ward St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location A. A. Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 St Paul St

JUN 28 1945 (b) Thos. Turpin for Williams, M.H.O.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945, at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1945, to 6/28 1945, and that I last saw h[illegible] alive on 6/25 1945.

Immediate cause of death Resp. failure

Due to Cerebral metastases

Due to Carcinoma Ovary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Cattell

Address Redwood & Greene Sts Date signed 6/28/45 D.

G30239
AB-92993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

G30239
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-17days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 S. Regester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1919 25?

8. AGE: Years	Months	Days	If less than one day
25?	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Neal
13. Birthplace ?

MOTHER
14. Maiden Name Amy
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brentwood Ave Huntington Williams, Md.

19 (a) (Date received by registrar)

JUN 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24- 1945 . at 5.10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7- 19 45. to 6-24 19 45.
and that I last saw h im alive on 6-24- 1945 .

Immediate cause of death Cardiac insufficiency — Duration 2 months

Due to Coarctation Aorta — ?

Due to Rheumatic heart disease — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 6-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G30240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: D.O.A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4-12
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: 636 W. Fayette St Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME John W. Hickman

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1-7-1900

8. AGE: Years: 45 Months: 5 Days: 20 If less than one day: hr. min.

9. Birthplace: Crisfield Md. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: John Wilmer
13. Birthplace: Crisfield, Md.

MOTHER
14. Maiden Name: Alice J Massey
15. Birthplace: Crisfield, Md.

16 (a) Informant: Elsie Hickman
(b) Address: Crisfield, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-29-45 (month) (day) (year)
(c) Cemetery or crematory: Crisfield, Md.
Howard Hubbard,

18 (a) Funeral director: Wm Cook & Sons
(b) Address: ~~12-7 St Paul St.~~ Crisfield Md.

19 (a) (Date received by registrar) (b) Registrar

VS 1 JUN 29 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 1945, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions: Chronic Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: P. L. Lubinski M.D. Medical Examiner.
Date signed: 6/27/45

G30241

AB.-94367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a.

G30241 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Cookie Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Smolski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1-1898

8. AGE: Years	Months	Days	If less than one day
46	7	27	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Simon Smolski
13. Birthplace Russia

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (month) 30 (day) 45 (year)
(c). Cemetery or crematory St Stanislaus Cem
Location Baltimore Co.

18 (a) Funeral director John M. Weber
(b) Address 40 S. Chester Street

19 (a) Date received by registrar Huntingtn Williams M.D.

JUN 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28- 1945, at 4.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25- 1945, to 6-28- 1945, and that I last saw him alive on 6-28- 1945.

Immediate cause of death Coronary occlusion? — Duration 3 days

Due to

Due to

Other Conditions Shock

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 6-28-45

G30242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30242 Registered No. 170C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 S. Durham Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Andrew Kalinowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife.....

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1940

8. AGE: Years 4 | Months 8 | Days 28 | If less than one day .....hr. .....min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name WALTER KALINOWSKI
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name STELLA URBANOWSKI
15. Birthplace BALTIMORE, MD.

16 (a) Informant MR. WALTER KALINOWSKI
(b) Address 715 S. DURHAM ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6|30|45 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD

18 (a) Funeral director M. J. Sadowski Estate
(b) Address 828 Eastern Ave

19 (a) JUN 29 1945 (Signature of registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury June 27 1945 — 3:30 P.M.
(b) Where did injury occur? Durham St. 83' north of Lancaster Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by truck

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed June 28 1945

G30243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G30243 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fidwood & Green Sts
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Lemon St.
Lemon (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Hill

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	M Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885 May

8. AGE: Years	Months	Days	If less than one day
60	1		hr. min.

9. Birthplace Hutchinson Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Hill
13. Birthplace Va

MOTHER
14. Maiden Name Margaut Cook
15. Birthplace Va

16 (a) Informant Mary Hill
(b) Address 1825 Lemon St

17 (a) Burial (b) Date thereof 6 30 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Druestman St

19 (a) (b) Huntington Williams

JUN 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 19 45 at 3 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/26 19 45 to 6/27 19 45
and that I last saw h[illegible] alive on 6/27 19 45

Immediate cause of death	Duration
Cerebro-vascular accident	
Due to Hypertension & arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Emig, M.D.
Address Univ. Hosp. Date signed 6/29/45

X

G30244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G30244

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves

(c) Hospital or institution: St Agnes Hospital 4 ← 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 704 N. Lombard St. (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country Bohemia

3 (a) FULL NAME Mr Albert Mathis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Wife Teresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-3-76

8. AGE: Years	Months	Days	If less than one day
69		24	hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Bar tender

11. Industry or business Entertainment

FATHER

12. Name Frank Mathis

13. Birthplace Bohemia

MOTHER

14. Maiden Name Julia Roffat Lee

15. Birthplace Bohemia

16 (a) Informant Mrs Theresa Mathis

(b) Address 704 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location 4430 Belair Road

18 (a) Funeral director John F Conway & Son

(b) Address 901 Hollins St

19 (a) Date received by registrar JUN 29 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1945 at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 1945 to 6-27 1945, and that I last saw h[illegible] alive on 6-27 1945.

Immediate cause of death	Duration
Carcinoma of gall bladder direct metastasis to liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence [illegible] at [illegible] M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jose M Olivares de Chaudens M.D.

Address Date signed 6/27/45

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G30245 Copies

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G30245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 528 N. Chester St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 528 N. Chester St
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Barbara G. Pfaff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George J. Pfaff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1870

8. AGE: Years	Months	Days	If less than one day
74	8	7 27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Conrad Maier
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Joeckel
15. Birthplace Germany

16 (a) Informant George J. Pfaff
(b) Address 528 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Frank Ovach & Son
(b) Address 900 Chester St.

19 (a) JUN 29 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945, at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945 to June 27 1945 and that I last saw h[illegible] alive on June 27 1945.

Immediate cause of death	Duration
Ltg Post Viral Pneumonia	6/24/45
Due to Chr. Myocarditis	6/1/44
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature William J. Pfaff M.D.

Address 801 N Kenilworth Date signed 6/28/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G30246

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto. city

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1941 E. 31st St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Lawrence Mallonee

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-2489

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband ~~or wife~~ Katherine Mallonee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21-1885

8. AGE: Years	Months	Days	If less than one day
59	9	7	hr. min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Balto Transit Co-

11. Industry or business

FATHER

12. Name Lawrence Mallonee

13. Birthplace Md.

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs Lawrence Mallonee

(b) Address 1941 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md.

18 (a) Funeral director L. J. Kluge

(b) Address 5315 Harford Rd

19 (a) JUN 29 1945 (b) Humphrey Williams, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28 1945, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31- 1945, to 6-28 1945, and that I last saw ~~him~~ her alive on 6-28 1945.

Immediate cause of death Respiratory Failure

Due to Carcinoma Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma Both Lungs, Mediastinal Nodes, Liver, Multiple Lung abscesses

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St. Josephs Hosp. Date signed 6-28-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120

Registered No. G30247

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 229 S. Hilton St.

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 229 S. Hilton St
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Jessie M. Creamer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph Creamer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 26 - 1878

8. AGE: Years	Months	Days	If less than one day
66	10	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Household duties -

FATHER
12. Name Geo. W. Peacock
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Seabright
15. Birthplace Md

16 (a) Informant Mrs. Rosalie Lutz

(b) Address 229 S. Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 30 - 45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Geo. L. Beyer Jr.

(b) Address 1512 Hollins St

19 JUN 29 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 3 1945 to June 27 1945 and that I last saw her alive on June 27 1945.

Immediate cause of death Acute dilatation of heart — Duration 30 m.

Due to acute nephritis — 3 mos.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature R. E. Campbell

Address 1644 Hanover St Date signed 6/28/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G30248 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1302 Harlem ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1302 Harlem ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Harrison Bryant

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colrd | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cornelia Bryant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Columbia, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John H. Bryant

13. Birthplace S. C.

MOTHER 14. Maiden Name Annie —

15. Birthplace S. C.

16 (a) Informant Cornelia Bryant

(b) Address 1302 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director James A Hayes

(b) Address 2442 W. Pratt St.

JUL 29 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 1015

20. DATE OF DEATH June 27 1945 at am

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1945 to 6-27-1945, and that I last saw him alive on 6/26 1945.

Immediate cause of death Chronic Cardiovascular Renal disease — Duration 4 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address 610 Washington [illegible] 6/28/45

X

VS 150

1 Th 30249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12a G30249

Registered No. G30249

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1411 Ashland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1411 Ashland Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1891

8. AGE: Years 54 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Griffin

13. Birthplace Md.

MOTHER 14. Maiden Name Amelia ?

15. Birthplace Md.

16 (a) Informant Beatrice Perry

(b) Address 1411 Ashland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1 / 45
(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location A. A. County Md.

18 (a) Funeral director Wm. Robert A. Elliott Dept

(b) Address 112 [illegible]

19 (a) June 29 1945 (b) [illegible]
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 June 1945, at 9.11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 June 1945 to 28 June 1945 and that I last saw h[illegible] alive on 28 June 1945

Immediate cause of death Acute cardiac dilitation — Duration

Due to Malignant hypertension.

Due to Cardio renal disease.

Other Conditions Senile Neurasthenia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert C. Bunnell M. D.

Address 121 Augusta St Date signed 29 June 45

VS 150

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

✓ G30250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

Registered No. G30250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Res
(d) Street No. Wilkens & Caton Aves. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Schwabland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-93

8. AGE: Years 51 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Peter Conrad (dec.)
13. Birthplace ~~Germany~~ Germany

MOTHER
14. Maiden Name Hannah Hoerr (dec.)
15. Birthplace Md.

16 (a) Informant Mrs. Bertha Schwabland
(b) Address 1701 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location C. J. Co. Md.

18 (a) Funeral director Martin Baker & Sons
(b) Address 1827 W. North Ave.

19 (a) (b) (Signature of registrar) Huntington Williams, M.D. Registrar

JUN 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1945 to 6-29 1945 and that I last saw him alive on 6-29 1945

Immediate cause of death: Intestinal Obstruction — Duration
Due to: Cause undetermined
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 6/28/45
Major findings of operation: Gall bladder & part of liver removed
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Carroll M.D.
Address St. Agnes Hosp. Date signed 6/29/45 M.D.

G30251

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G30251

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Sarratoga
(c) Hospital or institution: Mercy-hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va - (b) County -
(c) City or town Newport News (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 - 32nd. S.T. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Weissenberger

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ida L. Eilen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Merchant-

11. Industry or business Buyer-

FATHER
12. Name Charles Weissenberger
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Weisen.
15. Birthplace Germany

16 (a) Informant Dr. F. Gillis
(b) Address Mercy hosp-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 45 (month) (day) (year)
(c) Cemetery or crematory New Cath.
Location Old Frederick Rd.

18 (a) Funeral director John J. Modan
(b) Address 420 Fremont Ave

19 (a) (Date) JUN 29 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28-45 19 , at N-M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1945 to 6-28-1945, and that I last saw h[illegible] alive on 6-28 1945

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertension-

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None -
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William W. Osborne M.D.
Address Mercy hosp Date signed 6-28-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G30252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G30252 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Elvaton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar H. Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Marian Redmond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27th 1892

8. AGE: Years	Months	Days	If less than one day
53	3	0	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Md. Dry Dock

FATHER
12. Name Robert Redmond
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Marian Redmond
(b) Address Elvaton Md

17 (a) Burial (b) Date thereof 7/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys Hompden
Location Baltimore Md

18 (a) Funeral director Milburn Co Inc.
(b) Address 1214 E Cont St

19 (a) Date rec'd by reg. JUN 29 1945 (b) Washington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945, at 9:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-23-45 a.a. bet. M.
(b) Where did injury occur? Glenburnie
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by train.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 28 1945

G30253
AB-84219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

70

G30253
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-8mos- 20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Mooney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8- 1880

8. AGE: Years	Months	Days	If less than one day
64	11	19	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Mooney
13. Birthplace Ireland

MOTHER
14. Maiden Name Marion Garner
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Young Byers
(b) Address 5005 Park Heights Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 29 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27- 1945, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1943 to 6-27 1945, and that I last saw him alive on 6-27- 1945

Immediate cause of death Cardiac failure — Duration ?

Due to Pulmonary Infarction — ?

Due to Arteriosclerosis — ?

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anatomic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Date signed 6-28-45

G30254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G30254 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution: Redwood + Green St. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Grant Eckert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary L Eckert
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) May 30-1862

8. AGE: Years	Months	Days	If less than one day hr.	min.
83	8	28		

9. Birthplace Hanover Pa
(Town, county, and state)

10. Usual Occupation Ret Railroad Cond.
11. Industry or business W. M. Railway

FATHER
12. Name John Eckert
13. Birthplace Penna

MOTHER
14. Maiden Name Adaline Johnson
15. Birthplace Penna

16 (a) Informant Mrs Frank E Jackson
(b) Address Buffalo, N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Hanover Penna

18 (a) Funeral director J. F. Elbert Sons
(b) Address Westminster Md

19 (a) JUN 29 1945 Huntington Williams, M.D.
(Registrar) (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28 1945 at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1945 to 6-28 1945 and that I last saw him alive on 6-28 1945.

Immediate cause of death Apoplexy

Due to

Due to

Other Conditions Fracture left femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 0/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-26-45 at ? M
(c) Where did injury occur? Balt. Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury fell in back yard

23. Signature Howard J. Mendelsohn M. D.
Address Univ. Hosp. Date signed 6-28-45

Howard J. Mendelsohn, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 a

Registered No. G30255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4214 Curtis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Curtis Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes M. Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Addison Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 - 1883

8. AGE: Years 61 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Partridge
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Mullinaux
15. Birthplace

16 (a) Informant Addison Johnson
(b) Address 4214 Curtis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory Marley Md.
Location A. G. Co.

18 (a) Funeral director Flynn & Flannery
(b) Address 1426 Light St.

19 (a) JUN 29 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 45, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to June 28 1945, and that I last saw him alive on June 27 19 45.

Immediate cause of death: Carcinoma head — Duration

Due to disseminated

Due to Hypertension Arteriosclerosis

Other Conditions arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Patapsco Date signed

X

G30256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30256

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Maria Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband ~~or wife~~ Bernard Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26-1875

8. AGE: Years	Months	Days	If less than one day
69	7	3	hr. min.

9. Birthplace Frederick County Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clayton Smuddle
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Sappington
15. Birthplace Maryland

16 (a) Informant Catherine L. Wagner
(b) Address 1738 Eastern Ave - Balto.

17 (a) Burial (b) Date thereof July 3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Libertytown, Md.

18 (a) Funeral director Powell & Hartman
(b) Address Woodbourne Md.

JUN 30 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 1.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945, to June 29 1945, and that I last saw h[illegible] alive on June 29 1945.

Immediate cause of death: Arteriosclerosis Cardiac
Antecedent Renal disease

Duration
7

Due to

Due to

Other Conditions Cardiac decompensation 6 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur L. Schwartz M. D.
Address 5939 Dr. Date signed 6/29/45

VS 150

G30257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G30257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 2505 Pennsylvania Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Birka

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

UNIVERSITY MEDICAL SCHOOL JUN 29 1945

18 (a) Funeral Director Commissioner of Health
(b) Address

19 (a) JUN 30 1945 (Date rec'd by registrar) (Huntington Williams M.D.)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 45 19 , at 6.45 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 18, 1945.

G30258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30258

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Moseley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 29 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945 at 3 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ ~~accident~~ ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Empyema
Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 20 1945

2798

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30259
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 325 N. Pearl St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jeff Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 29 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 7 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gangrene of Intestine

Due to Strangulated Inguinal Hernia

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed June 19 1945

SZYMKOWIAK

G30260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G30260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 S. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Szymkowiak.
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-03-5775

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of wife Katherine
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) FEB-24-1892

8. AGE: Years 53 | Months 0 | Days 0 | If less than one day hr. 1 min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business M. A. KATZEN & CO

FATHER
12. Name ADALBERT SZYMKOWIAK
13. Birthplace POLAND

MOTHER
14. Maiden Name KATHERINE SCHNIEDER
15. Birthplace POLAND

16 (a) Informant MRS KATHERINE SZYMKOWIAK
(b) Address 524 So. Dallas street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George E. Weber
(b) Address 703 E Biddle st

19 (a) JUN 30 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28 1945 at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1945 to 6/28 1945 and that I last saw him alive on 6/28 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Cerebro Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following: N/A
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6/24/45 9:15 AM
(c) Where did injury occur? Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps

23. Signature Melvin J. Jaworski M.D.
Address St Joseph Hosp Date signed 6/28/45

approved thomas f. [illegible] M.D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G30261 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilman Apts., Calvert & 31st Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) ~~Street~~ No. 2 Calvert & 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE W. DORP

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Martin W. Dorp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1871

8. AGE: Years	Months	Days	If less than one day
73	7	21	hr. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Edward Winchell
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Sarah Warren
15. Birthplace: Del.

16 (a) Informant: Mrs. C. Albert Hanson, Jr.
(b) Address: Calvert & 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) [illegible] Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1939, to June 28 1945, and that I last saw ~~him~~ her alive on June 27 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs.
Due to Hypertension	10 yrs.
Due to	
Other Conditions (Paget's) Osteitis deformans	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Corner M.D.
Address 38 W 25th St. Date signed 6-29-45

VS 180

X

G30262

G30262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 Presstman St
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Presstman St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Clara E. Fossett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race colored

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife George Fossett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1874

8. AGE: Years 71 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George (Priadow) PREADOW
13. Birthplace Md

MOTHER
14. Maiden Name Jennie Henry
15. Birthplace Md

16 (a) Informant George Fossett
(b) Address 1831 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-45 (month) (day) (year)
(c) Cemetery or crematory Berlin Md
Location Md

18 (a) Funeral director George E. Kelson
(b) Address 1303 Presstman St

19 (a) (Date received) JUN 30 1945 Huntington Park, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1944, to Jun 29 1945 and that I last saw her alive on Jun 28 1945.

Immediate cause of death Cancer of Uterus — Duration 4 yrs 4 mos

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Pettigrew M. D.

Address 417 Hamilton Ave Date signed June 30/45

G30263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G30263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Newsome

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1945

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Newsome
13. Birthplace

MOTHER
14. Maiden Name Cora Dean
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory JOHNS HOPKINS MEDICAL SCHOOL JUN 28 1945
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 30 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 11:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23-45 1945, to 6-25 1945, and that I last saw him alive on 6-25- 1945.

Immediate cause of death prematurity and intracranial hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D. Griffith M. D.
Address Johns Hopkins Hospital Date signed 6-25-45

2803

G30264 #75291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30264

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 - C
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Marlene Green -

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1917

8. AGE: Years 28 | Months — | Days 10 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Hutton

13. Birthplace Md -

MOTHER 14. Maiden Name Mary Kane -

15. Birthplace Md -

16 (a) Informant Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 2 - 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A.A. Co., Md.

18 (a) Funeral director Charles K. Law

(b) Address 802 Madison Ave.

19 (a) Date received by local registrar JUL 3 0 1945 (b) Registrar's signature for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945 at 10 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 28 1945 and that I last saw her alive on June 28 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Hypertensive Cardiovascular Disease with cardiac failure -	
Due to Uremia	
Other Conditions Nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilbur T. Dixon
Address Johns Hopkins Hospital Date signed 6/29/45

X

G30265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30265 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lively

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie M. Lively

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11, 1886

8. AGE: Years 58 | Months 10 | Days 17 | If less than one day hr. min. 16

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business University of Maryland

FATHER 12. Name Braxton Lively

13. Birthplace Maryland

MOTHER 14. Maiden Name Grace Tervis

15. Birthplace Westmoreland Va

16 (a) Informant Minnie M. Lively

(b) Address 806 W. Saratoga Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Western Star Cemetery

Location Baltimore County, Md.

18 (a) Funeral director Joseph A. Lively

(b) Address 1991 Mount Street

19 (a) (Date received by Registrar) JUN 30 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945 at 7 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.

Date signed June 27 1945

Huntington Hillcrest, M.D.

G30266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G30266 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6408 Eastbourne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6408 Eastbourne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Asda Mildred Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James A Fisher

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan 20th 1894

8. AGE: Years 51 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace 13 Allegany (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name James McDonnel
13. Birthplace Md

MOTHER
14. Maiden Name Virginia Perkins
15. Birthplace Md

16 (a) Informant James A Fisher
(b) Address 6408 Eastbourne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) JUN 30 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to June 28, 1945, and that I last saw h alive on June 28, 1945.

Immediate cause of death Carcinomatosis

Duration 1 yr.
9 mo.

Due to Carcinoma cervix of uterus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Ambrose M. D.
Date signed 6/29/45

VS 150

G30267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G30267

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden Ave. & Lake Drive. Riviera Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-1

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Riviera Apts. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME BENJAMIN J. BURGUNDER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1887.

8. AGE: Years	Months	Days	If less than one day
57	10	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Clothing Sales-
11. Industry or business man.

FATHER

12. Name Joseph Burgunder, Jr.

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Theresa Gundersheimer,

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Milton Burgunder,

(b) Address 2342 Eutaw Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/45. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Balto. Md.

18 (a) Funeral director Bland Sondheim & Son

(b) Address 1902 Eutaw Place.

19 (a) JUN 30 1945 Registrar

(Date received by Registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29th. 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1944, to June 29 1945, and that I last saw h[illegible] alive on June 29 1945.

Immediate cause of death	Duration
Uremia & Cardiac failure	1 week
Due to Cerebral hemorrhage	10 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. Frederick Lentz M. D.

Address Temple Garden Apts Date signed June 30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G30268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 479 Orchard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 -
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 479 Orchard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert A. Pannell

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-03-8538

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna
6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 5-11-1906

8. AGE: Years: 39 | Months: 1 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Lynchburg, Va.
(Town, county, and state)

10. Usual Occupation: Grill
11. Industry or business:

FATHER
12. Name: Robt Pannell
13. Birthplace: Va.

MOTHER
14. Maiden Name: Lucy ?
15. Birthplace: Va.

16 (a) Informant: Edna Pannell (wife)
(b) Address: 479 Orchard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Balto Md.

18 (a) Funeral director: Chas J Gruber
(b) Address: 52 Cangelosi Ave

JUN 30 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26/45 19..... at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 19 45 to June 26 19 45 and that I last saw h— alive on June 26 19 45.

Immediate cause of death: Cancer of Lung

Duration: 3 mos

Due to

Due to

Other Conditions: None
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Pettiford M. D.
Address 5 E Madison Ave Date signed 6/30/45

630269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 630269

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1516 Front St (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Rheubottom

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: C.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-14-1873

8. AGE: Years 72 | Months 1 | Days 4 | If less than one day 12 hr. min.

9. Birthplace Balto md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or Business

FATHER
12. Name Jas Rheubottom
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Williams
15. Birthplace Virg

16 (a) Informant Rhoda Timms
(b) Address 623 Greenwillow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto. Md.

18 (a) Funeral director Charles H Doffley
(b) Address 512 Cancellor Ave

19 (a) JUN 30 1945 (Date rec'd by Registrar) Huntington Md Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26 1945, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30270

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43a

G30270 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Hanover St
(c) Hospital or institution:
2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Hanover St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Schoenfeld

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dead Man
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 186

8. AGE: Years 82 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace Germany (town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Gustave Schoenfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Rosettea Wiffler
15. Birthplace Germany

16 (a) Informant Mrs Lula Schoenfeld
(b) Address 1510 Hanover St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 2 1945 (month) (day) (year)

(c) Cemetery or crematory Western
Location Balto City

18 (a) Funeral director G. Kendel Evans
(b) Address 1400 Eutaw St

19 (a) JUN 30 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1945 to 6/28 1945 and that I last saw her alive on 6/28 1945.

Immediate cause of death: a Cerebral Hemorrhage — Duration: 8 hours
Due to —
Due to —
Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deiker
Address 1226 Hanover St Date signed 6/29/45

For P. J. Lubinski, by Howard F. Maddux, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G30271 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 W. OSTEND ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARIE S. DeCOURSEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM.

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife JOSEPH T DECOURSEY

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) MAY. 31-190 2

8. AGE: Years 43 | Months 0 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name WILLIAM BAUMAN
13. Birthplace BALTO MD

MOTHER
14. Maiden Name ELIZABETH B AULBACH
15. Birthplace BALTO MD

16 (a) Informant JOSEPH T DECOURSEY
(b) Address 1307 W OSTEND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE MD

18 (a) Funeral director Bernard C Harle
(b) Address 121 E WEST ST.

19 (a) (Date rec[illegible]) JUN 30 1945
Huntingtown, Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1945 at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945 to 6-29 1945 and that I last saw h[illegible] alive on 6-29 1945

Immediate cause of death 2 Resp. failure — Duration

Due to CARCINOMA of Colon
& metastasis to liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-22-45

Major findings of operation: SAME AS ABOVE

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George M. Lemmon M. D.
Address Univ. Hosp. Date signed 6-29-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G30272
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 St. Johns Road, Roland Pk.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town City of Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 St. Johns Road (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED J. McKAY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Virginia Cook McKay
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct-23-1872

8. AGE: Years 72 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Lynchburg Va (Town, county, and state)

10. Usual Occupation Accountant-U.S. Govmnt
11. Industry or business

FATHER
12. Name Alfred A. McKay
13. Birthplace Front Royal, Va.

MOTHER
14. Maiden Name Annie E. McKay
15. Birthplace Luray, Va

16 (a) Informant Mrs. Virginia C. McKay (wife)
(b) Address 627 St. Johns Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 (month) 45 (day) (year)
(c) Cemetery or crematory Prospect Hill Cem
Location Front Royal, Va.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Av. (W.F. Wooden-Suc.)

19 (a) JUN 30 1945 (Date rec'd by registrar) (b) Huntington Hillegass, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945, to June 29 1945, and that I last saw h[illegible] alive on June 29 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr
Due to: Myocarditis Arteriosclerosis — Duration: Years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W.H. Brady, M.D.
Address 140 3 Bel Air Date signed 6/30/45

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G30273 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore-16, Maryland.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIET ADALINE GESNER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elisur H. Gesner
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb-23-1865 ~~55~~

8. AGE: Years 90 | Months 4 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Catskill, New York
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William Colepaugh
13. Birthplace New York State

MOTHER
14. Maiden Name Caroline Ackley
15. Birthplace New York State

16 (a) Informant Maj. H. M. Gesner (son)
(b) Address 3015 Chelsea Terrace, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July-2-1945 (month) (day) (year)
(c) Cemetery or crematory Oak Grove (?) Co.
Location West Haven, New Haven, Conn.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City.

19 (a) (Date received by Registrar) JUN 30 1945 Huntington Williams (Registrar) (b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to June 29 1945, and that I last saw her alive on June 26 1945.

Immediate cause of death	Duration
Myocarditis -from history	3 wks
Due to Arteriosclerosis	?
Due to	
Other Conditions Myocarditis	2 mo

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles S. Nisbett, M.D.
Address 2803 Garrison Blvd. Date signed 6/29/45.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30274

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address III8 Ridgely, St,

(c) Hospital or institution:

217

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. III8 Ridgely, St. (If rural, give location) NO

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Emerson Shiloh

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-3062

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Margaret M. Shiloh

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov 23/1873

8. AGE: Years	Months	Days	If less than one day
71	7	6	..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Steel Co.

FATHER

12. Name Eugene Shiloh

13. Birthplace Baltimore

MOTHER

14. Maiden Name Rebecca Rush

15. Birthplace Baltimore, Md.

16 (a) Informant Margaret M. Shiloh

(b) Address III8 Ridegely, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2/45 (month) (day) (year)

(c) Cemetery or crematory Louden Park

Location Fredrick Rd

18 (a) Funeral director Ambrose Inc,

(b) Address 414 N. Franklintown, RD.

19 JUN 30 1945 (b) Huntington Mitchell Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 6 14 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to June 29 1945 and that I last saw him alive on June 29 1945.

Immediate cause of death	Duration
Cerebral Hemmorrhage	2 days
Due to	
Due to Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Schofield

Address 414 N. Franklintown Rd. Date signed 6/30/45 M.D.

X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G30275
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3223 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DEKA VIRGINIA LAMBERT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel Laurence Lambert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	6	hr. min.

9. Birthplace Florida
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Everett Wilcox
13. Birthplace Fla.

MOTHER
14. Maiden Name Elizabeth Lambert
15. Birthplace Fla.

16 (a) Informant Mrs. S. Shaum
(b) Address 2222 Walbrook Ave.

17 (a) Burial (b) Date thereof 6/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 30 1945 (b) Huntington Williams, M.D. Registrar
(Date Received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945 at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945 to 6-27-1945 that I last saw h er alive on 6-27-1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Due to Chr. Myocarditis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidson M. D.
Address 3218 Eastern Date signed 6-30-45

VS 150

G30276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G30276 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 Poultney St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Poultney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK WIESNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name John Wiesner
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Grenzar
15. Birthplace Germany

16 (a) Informant Mrs. Lillie Seward
(b) Address 40 Poultney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 30 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1945 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5, 1944 to 6/28/ 1945, and that I last saw him alive on 6/28/ 1945.

Immediate cause of death	Duration
Carcinoma of the prostate.	9 mos.
Due to - - -	
Due to - - -	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deikel Jr M.D.
Address 1226 Hanover St. Date signed 6/30/ 1945. M. D.

VS 150

G30277 G30277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined for correct age is especially important. Physicians: please write the causes of death clearly and legibly. OR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Edmonson Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto. City
(c) City or town 1814 Edmonson Avenue (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT J. FITZPATRICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Anna Fitzpatrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	28	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Batilion Chief
11. Industry or business Balto. City

FATHER
12. Name Joseph Fitzpatrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Cecelia Finnessey
15. Birthplace Ireland

16 (a) Informant Mr. Albert J. Fitzpatrick, Jr.
(b) Address 1928 W. Franklin St., 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 30 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/45 19 at 9 A.M.

21. I certify that I took charge of the remains described above, held an Inspection of Injuries thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Travis, M.D. Medical Examiner.
Date signed 6/29/45

G30278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST FRANKLIN MICKEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leona Hamm Mickey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	23	hr. min.

9. Birthplace Winston Salem, N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Consolidated Gas & Elec. Co.

FATHER
12. Name Tobian Oliver Mickey
13. Birthplace N. C.

MOTHER
14. Maiden Name Louisa Spainhower
15. Birthplace N. C.

16 (a) Informant Mrs. Ernest F. Mickey
(b) Address 3012 Belmont Ave.

17 (a) Burial (b) Date thereof 7/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hampstead, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 30 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945, at 9-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945 to June 29 1945 and that I last saw h[illegible] alive on June 29 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1½ hr.
Due to	
Due to	
Other Conditions Occluded pulmonary Tbc.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury?

23. Signature L. W. Sauerbrey, M.D.
Address 562 Lexington Bldg. Date signed 6/30/45 M. D.

Huntington Williams, M.D.

Balto-Med-Saunders

G30279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G30279
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calhoun St
(c) Hospital or institution: Fran Klin Sq Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severn (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Russell Jackson

27068

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/7/65

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Russell Jackson Sr
13. Birthplace

MOTHER
14. Maiden Name Hilda Jackson
15. Birthplace Laurel Md

16 (a) Informant Franklin Sq Hosp
(b) Address N. Calhoun St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JUN 30 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

E 2804

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945, to June 29 1945, and that I last saw him alive on June 29 1945.

Immediate cause of death: Bilateral Partial Atelectasis — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barbara L. Jones M. D.

Address Date signed

G30280
Dr. Baggott
3812 Greenmount Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G30280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 East 39th. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 East 39th. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillie W. Dengler

3 (b) If veteran, name war ---------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Dengler
13. Birthplace Germany

MOTHER
14. Maiden Name Annie E. Gerlach
15. Birthplace Germany

16 (a) Informant Emma M. Dengler
(b) Address 506 East 39th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director E. Ellsworth Ammeson
(b) Address 3911 Liberty Heights Ave.

19 JUN 30 1945 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 4: A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1945, to June 29 1945 and that I last saw her alive on June 28 1945.

Immediate cause of death	Duration
Metastatic carcinoma Lungs, Post. Mast. Carc.	1 yea
Due to Carcinoma R breast	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1940 Removal Left breast
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dailey M. Baggott M. D.
Address 3812 Greenmount Ave Date signed 6/29/45

VS 3

COEL

G30281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a Registered No. G30281

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2017 Druid Hill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2017 Druid Hill Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Eliza Wright Coel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James R. Coel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1881

8. AGE: Years 63 Months 7 Days 23 If less than one day hr. min.

9. Birthplace Wilmington N.C.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Douglass

13. Birthplace N.C.

MOTHER 14. Maiden Name Kate Brown

15. Birthplace Va.

16 (a) Informant Mildred K. Curtis

(b) Address 2017 Druid Hill Ave

17 (a) Burial (b) Date thereof 7/1/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lerbuture

Location

18 (a) Funeral director Robert L. Young

(b) Address 804 N. Carrollton Ave.

19 (a) JUN 30 1945 (b) Registrar
(Date rec'd by registrar)

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1945 to 6/27 1945 and that I last saw h[illegible] alive on 6/27 1945.

Immediate cause of death

Hypertension

Due to Cardiac Decompensation

Due to Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. M. B. Butler

Address 2033 Eutaw Pl Date signed 6/28/45

G30282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G30282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Baker

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 216-09-7071

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Anna —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1887

8. AGE: Years 58 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Baker
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie —
15. Birthplace Va.

16 (a) Informant Edna Redding (Daughter)
(b) Address 1316 Ashland Ave Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Council
(b) Address 804 E. Caroline St

19 JUN 30 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6- 1945 to 6-29- 1945 and that I last saw h/[illegible] alive on 6-29- 1945

Immediate cause of death Coma & Uremia — Duration ?

Due to

Due to

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey Harris, M.D.

Address 711 E 23rd St Date signed 6-30-45

VS 150

G30283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82B

Registered No. G30283

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1914 Hope street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1914 Hope Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANNA PULLEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles Pullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Dotter

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Delcher

15. Birthplace Germany

16 (a) Informant Miss Della Pullen-daughter

(b) Address 1914 Hope Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) JUN 30 1945 (b)
(Date rec'd by registrar)

Huntington Williams M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to June 1945.
and that I last saw alive on June 28 1945

Immediate cause of death Cardiac Insufficiency — Duration 2.

Due to Arteriosclerosis. — 7

Due to — 7.

Other Conditions Hypertension Cerebral Hemorrhage.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harold Jones M.D.

Address 1761 E. North Ave. Date signed 6/29/45

95c

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. G30284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Sterling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucile Pegram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grover Pegram

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-30-05

8. AGE: Years 39 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Ned Smith
13. Birthplace: Va.

MOTHER
14. Maiden Name: Minnie Gaines
15. Birthplace: Va.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Brantley Ave

19 (a) 1945 JUL (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6.27 1945 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1945 to 6-27 1945 and that I last saw her alive on 6-27 1945.

Immediate cause of death: Respiratory arrest — Duration: 6 days

Due to: Acute yellow atrophy of liver

Due to: Hemorrhagic serum jaundice

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

Signature: F. J. Dixon, M.D.

Address: Johns Hopkins Date signed 6/27/45

G30285 WARNER

BALTIMORE CITY HEALTH DEPARTMENT ✓ G30285

CERTIFICATE OF DEATH 109

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 W. Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Warner

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-8180

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna R. Warner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1885

8. AGE: Years 60 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Gen Truck Helper

11. Industry or business

FATHER 12. Name James E. Warner
13. Birthplace Unknown

MOTHER 14. Maiden Name Lydia Sharrard
15. Birthplace Unknown

16 (a) Informant Mrs Anna R. Warner
(b) Address 3214 W. Belvedere

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)

(c) Cemetery or crematory Asbury M.E. Church
Location Reisterstown, Md.

18 (a) Funeral director Sonja Bisgrai
(b) Address 5605 Park Heights Ave

19 JUL 1945 (by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27/1945 to 6/29/1945 and that I last saw h alive on 6/29/1945.

Immediate cause of death Septicemia — Duration

Due to Pneumonitis

Due to

Other Conditions Uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Chandler M.D., M. D.
Address Md Gen'l Hosp. Date signed 6/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45

G30286 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 THAMES St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Thames St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Baum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/83

8. AGE: Years 61 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Geo Baum
13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Seyfert
15. Birthplace Balto Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof July 2 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Ernest Burkowske
(b) Address 1401 Eastern Ave Rd

19 (a) (b)
(Date rec'd by registrar) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1943 to June 29 1945 and that I last saw h alive on June 28 1945

Immediate cause of death Cancer Maxillary
Forsa.

	Duration
	over 4 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen C. Bentham M.D.

Address 3139 E Baltimore Date signed 6-30-45

G30287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30287
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 Gwynn Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Gwynn Ave.
(If rural give location)
(e) Citizen of foreign country? Nc (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Bromwell Mullinix

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Amanda E.
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 7/17/1873

8. AGE: Years	Months	Days	If less than one day
71	11	12	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Andrew Mullinix
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Susan J. Beacraft
15. Birthplace Howard Co. Md.

16 (a) Informant Amanda E. Mullinix
(b) Address 350 Gwynn Ave. Balto. Md.

17 (a) Burial (b) Date thereof 7/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Howard Chapel
Location Long Corner, Howard Co. Md.

18 (a) Funeral director Daniel E. Pumphrey.
(b) Address 8434 Ga. Ave. Silver Spring

19 (a) Date received by registrar JUL 1 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 4.45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1940, to June 29 1945, and that I last saw h wife alive on May 16 1945.

Immediate cause of death Respiratory failure — Duration ½ hour

Due to Congestive heart failure — 2 weeks

Due to Generalized arteriosclerosis & arteriosclerotic cardiovascular disease — 4 years.

~~Other Conditions~~

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Zappe, M.D.
Address 3010 Baltimore Av. Date signed 6/29/45

X

G30288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 N Calhoun Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 N. Calhoun (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1873

8. AGE: Years 72 Months - Days 18 If less than one day hr. min.

9. Birthplace New York City, N.Y. (Town, county, and state)

10. Usual Occupation Window Cleaner

11. Industry or business

FATHER 12. Name Joshua Howard

13. Birthplace N.Y.

MOTHER 14. Maiden Name Alyata Cunard

15. Birthplace France

16 (a) Informant Estelle Howard

(b) Address 1117 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Balto. Md.

18 (a) Funeral director Mrs. Geo. V. Hall

(b) Address 1631 Pennsylvania Ave

19 (a) 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28 1945, at 8:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Nature of injury

22. Signature D. J. Galvinski M.D. Medical Examiner.

Date signed 6/29/45

VS 151

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-933 C30289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C30289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos- 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Clements Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Richard Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1917

8. AGE: Years 27 | Months 1 11 | Days 6 | If less than one day hr. min.

9. Birthplace Greenville, S.C.
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER
12. Name Roy Clements
13. Birthplace Greenville, S.C.

MOTHER
14. Maiden Name Hattie Humbert
15. Birthplace Greenville, S.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof July 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Wm. Chas. H. Hudson
(b) Address 1631 Druid Hill Ave.

19 (a) 7-2-45 Carrington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28- 1945, at 3.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30- 1945, to 6-28 1945, and that I last saw h er alive on 6-28- 1945.

Immediate cause of death: Pulmonary tuberculosis bilateral — Duration: 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hillon M. D.
Address Balto City Hosp. Date signed 6-28-45

VS 150

416272 G30290 BALTIMORE CITY HEALTH DEPARTMENT G30290

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Cecil County
(c) City or town Chesapeake City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clement Vaughn Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	- - - -

6 (b) Name of husband or wife - - -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-40

8. AGE: Years	Months	Days	If less than one day
5	3	26	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation - - -

11. Industry or business - - -

FATHER
12. Name Clement Vaughn
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Hyland
15. Birthplace Maryland

16 (a) Informant JOHNS HOPKINS HOSPITAL records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery or crematory St. Rose Cemetery
Location Chesapeake City Maryland

18 (a) Funeral director Maging V. Williams
(b) Address Chesapeake, Maryland

19 (a) (Date received by registrar) (b) Signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 2:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to June 30 1945 and that I last saw him alive on June 30 1945.

Immediate cause of death Congenital heart disease
Ventricular fibrillation — Duration: Life less 1 day

Due to Cong. heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None except cong. ht. disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter M. Tasem

Address J. H. H. Date signed 6/30/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Oli-St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 415 N. Oli-St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bessie M. Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 28th-1884

8. AGE: Years 61 | Months — | Days — | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Stewart

13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Matthews

15. Birthplace Balto Md

16 (a) Informant Pearl Adkins

(b) Address 413 N. Oli-St

17 (a) Burial (b) Date thereof 7-1st 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location B. A. Co. Md.

18 (a) Funeral director Byron Augustus H. Knight

(b) Address 725 Pasquill St

19 (a) JUL 5 1945 (b)
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945, to June 28 1945.
and that I last saw h[illegible] alive on June 27 1945.

Immediate cause of death Aortic Insufficiency — Duration One year

Due to

Due to

Other Conditions General Arteria Sclerosis — One year
Pharine Nephritis, Hypertension
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J. Young, M. D.

Address 4 E 24 St Dr Date signed 6/29/45

92a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G30292 92

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Harry Myers
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Kathleen Valentine
15. Birthplace Balto. Md.

16 (a) Informant Elsie Valentine
(b) Address 1112 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Nicholas Hallstead
(b) Address 918 Edmondson Ave.

19 (a) JUL 1 1945 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1945 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1945 to 6/29 1945; and that I last saw him alive on 6/29 1945. Died not attended at home.

Immediate cause of death Asphyxia

Due to Possibly to atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wayland E. Jones M. D.

Address 1300 N. Fremont Ave. Date signed 6/30/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G30293 CERTIFICATE OF DEATH 13 B

✓ G30293 93 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William O. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 188[illegible]

8. AGE: Years: 64 | Months: 2 | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name William O. Smith
13. Birthplace Md.

MOTHER 14. Maiden Name Mariah
15. Birthplace Md.

16 (a) Informant Mrs. Smith
(b) Address 929 Madison Ave

17 (a) Burial (b) Date thereof 7/2/45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 [illegible]-1945 (b) Huntington Williams, M.D. Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION 00

20. DATE OF DEATH June 29, 1945 at 10A, M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 30 1945 to June 29 1945 and that I last saw he alive on June 28 1945.

Immediate cause of death: Chronic nephritis — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature H. S. Pelletier M. D.
Address 817 Hamilton Date signed June 30 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Traynham G30294 4

Registered No. 117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Bolt
(b) Street address 501 Hoffman
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Hoffman
(If rural give location)
(e) Citizen of foreign country? W (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Traynham

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo.) April 9, 22

8. AGE: Years	Months	Days	If less than one day
22	7		hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business Private
12. Name of FATHER Joseph Traynham
13. Birthplace Virginia
14. Maiden Name of MOTHER Sallie Brown
15. Birthplace Virginia
16 (a) Informant Sallie Traynham
(b) Address 701 W. Hoffman St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)
(c) Cemetery or crematory Dennison
Location Virginia
18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave
19 (a) 7-11-1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/45 7:A M
21. I certify that death occurred on the date above stated; that I attended deceased from 6/9/45 to 6/9/45, and that I last saw he alive on 6/9/45.
Immediate cause of death Gastritis
Due to Hyperacidity ?
Due to
Other Conditions Pregnancy 5 months
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Operation —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 6/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G30295 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Linden Ave
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Russell Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1881

8. AGE: Years	Months	Days	If less than one day
64	8	7	hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation Freight Clerk

11. Industry or business B. & O. R.R. Co.

FATHER
12. Name Francis H. Bowman
13. Birthplace Pa.

MOTHER
14. Maiden Name Adelaide Sabel
15. Birthplace Pa.

16 (a) Informant Mrs. Ethel S. Stalnaker
(b) Address 411 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director J. B. Wolfort Son
(b) Address 1300 Eutaw Pl

19 (a) [illegible] 1945 Huntington Williams, M.T. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1945 to June 30 1945 and that I last saw h[illegible] alive on June 23 1945.

Immediate cause of death Coronary occlusion. — Duration

Due to Arteriosclerosis. myocarditis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence June 30 at 9 A M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Ernest Sachse M. D.
Address 12 E Eager St Date signed 6/30/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G30296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 536 Lauren St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 536 Lauren St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruby M. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1904

8. AGE: Years 40 41 | Months 11 | Days 25 | If less than one day hrs. min.

9. Birthplace Forest, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Smith

13. Birthplace Va

MOTHER 14. Maiden Name Julia Scott

15. Birthplace Va

16 (a) Informant Marie Brown

(b) Address 536 Lauren St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Cem

Location Bedford Co. Va

18 (a) Funeral director Mrs. Jas. H. Stafford

(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS Form 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1944 to 6/29 1945, and that I last saw h[illegible] alive on 6/24 1945.

Immediate cause of death Acute Pulmonary Intercurrent Diabetes Mellitus

Duration

Due to Hypertension

Other conditions Chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 6/30/45

X

G30297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30297 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Quantico Ave
(c) Hospital or institution: 1512
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-9252

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace London (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Grocer

FATHER
12. Name Simon Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Leah Solomon
15. Birthplace Russia

16 (a) Informant Mrs Albert Fleishmann
(b) Address 2614 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1945 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

JUL 1 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 12.30

20. DATE OF DEATH June 30, 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 19 , to June 29 45 and that I last saw him alive on June 29 19 45

Immediate cause of death: Acute Coronary Thrombosis

Due to: Ch Coronary Sclerosis

Due to: Ch Hypertension

Other Conditions: Ch Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein

Address 733 Argyle St Date signed 6/30/45 M.D.

VS 150

G30298 G30298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 S. Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 S. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeannette Mestafe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Allie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Israel Zass
13. Birthplace Russia

MOTHER
14. Maiden Name Goldie ?
15. Birthplace Russia

16 (a) Informant Allie Mestafe
(b) Address 232 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUL 2 1945 (Date received by registrar) Harrington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 1945 at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) and find from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulated Inguinal Hernia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Levinson M.D. Medical Examiner.
Date signed 6/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE FOR BINDING

G30299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30299 Registered No. 55E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Knowville, Lenna
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Meyer Frohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Lena Frohman

(b) Address 3012 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1439 E. Balto. St

19 (c) JUL 1 1945 (Date received by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1945, at 2 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1945, to 6-29 1945, and that I last saw h[illegible] alive on 6-29 1945.

Immediate cause of death Pulmonary edema

Due to Cardiac failure

Due to Blood dyscrasia - probably lymphosarcoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome R. Harlem M. D.

Address Sinai Hospital Date signed 6-29-45

G30300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

G30300 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Old Spring & Belvedere Ave

(c) Hospital or institution Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. Old Spring & Belvedere Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Coplin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Rena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Rtr

11. Industry or business

FATHER 12. Name

13. Birthplace Russia

MOTHER 14. Maiden Name

15. Birthplace Russia.

16 (a) Informant Adam Coplin (son)

(b) Address 3310 Tioga Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1-45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mills Rd

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1138 E. Balto. St.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1945, at 4.55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1943 to 6-29 1945 and that I last saw h[im] alive on 6-29 1945

Immediate cause of death: Unemployed arteriosclerosis Parkinson's Syndrome — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H Edmund Levin M. D.

Address Levindale Date signed 6/29/45

G30301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30301 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2473 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leah Brash

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 86 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Supt Reinde
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Israel
Location Southern Ave

18 (a) Funeral director Jenk Sons Inc Balto
(b) Address 1439 E. Balto St

19 (a) Filed by registrar 1946 (b) Registrar for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1945, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1945, to 6-30 1945, and that I last saw her alive on 6-30 1945.

Immediate cause of death Uremia — Duration

Due to Hypertensive and Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L. Darbin M. D.
Address Sinai Hospital Date signed 6-30-45

G30302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30302

Registered No. 14a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Raynor
(c) Hospital or institution West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 28 N. Chester St
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB BUDOFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Rebecca -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Harry -
13. Birthplace Russia

MOTHER
14. Maiden Name Mary -
15. Birthplace Russia

16 (a) Informant Mrs. - Rebecca Rudoff
(b) Address 28 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8 45 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Md
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Baltimore St

19 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/45 19..... at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Evans M.D.
Date signed 6/29/45 Medical Examiner.

1 Trans

AB- 94858 G30303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G30303 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1127 N. Caroline St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3 (a) FULL NAME: Isaiah Stafford

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Sarah Beeker Stafford

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 14- 1892

8. AGE: Years: 52 | Months: 8 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Huckster

11. Industry or business:

FATHER

12. Name: John Stafford (D)

13. Birthplace: N.C.

MOTHER

14. Maiden Name: Mary Johnson (D)

15. Birthplace: Md.

16 (a) Informant: Baltimore City Hospitals (Records)

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2 '45 (month) (day) (year)

(c) Cemetery or crematory: Mt. Olivet Cem. Location: Baltimore Co. Md.

18 (a) Funeral director: Mrs Robert O. Elliott Jr.

(b) Address: 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JUL 1 1945 VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945, at 7.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23- 1945, to 6-28- 1945, and that I last saw him alive on 6-28- 1945.

Immediate cause of death	Duration
Cardiac insufficiency	?
Due to:	
Due to:	
Other Conditions: Lymphatic Leukemia	

Operation: Neoplasm (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature E Woodward M. D.

Address: Baltimore City Hospitals Date signed 6-30-45

95c

2 Tran G30304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G30304 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Ann Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	12	hr. min.

9. Birthplace Caroline County Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Frances Taylor
15. Birthplace Va.

16 (a) Informant Lillian Tyson
(b) Address 3112 Brentwood Ave

17 (a) Burial (b) Date thereof July 2 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Q & A County Rds.

18 (a) Funeral director Mrs. Robert V. Elliott
(b) Address 1129 N. Carrollton Ave.

19 (a) Date received 1945 by Livingston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 45, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 28 1945 and that I last saw h alive on June 28 1945

Immediate cause of death: Chronic Interstitial Nephritis — Duration: 2 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2329 Guilford Ave Date signed June 30 1945

G30305 BALTIMORE CITY HEALTH DEPARTMENT G30305

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Harcourt Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot Easton
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Auria St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Albert MATTHEWS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Hattie B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace EASTON (Town, county, and state)
10. Usual Occupation Machine
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant KATIE MATTHEWS
(b) Address 104 AURIA

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md

18 (a) Funeral director Joseph Kaminkow
(b) Address 602 Federal Blvd

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

JUL 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to July 1 1945
and that I last saw h. /M alive on July 1 1945.

	Duration
Immediate cause of death Myocardial Insufficiency	1 day
Due to Cardio-renal-Vascular Disease	4 yrs
Due to Diabetes Mellitus	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Polsinelli M. D.
Address 617 W. 40th St Date signed 7/1/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G30306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30306

Registered No. 462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Columbia Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Dangel Shipe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wife Mona

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-22

8. AGE: Years 23 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation Cab driver

11. Industry or business Shaw's Cab Co.

FATHER
12. Name Roy Shipe
13. Birthplace W. Va.

MOTHER
14. Maiden Name Zella Lowe
15. Birthplace W. Va.

16 (a) Informant Hospital Records.
(b) Address St Agnes Hos.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)
(c) Cemetery or crematory Mathias
Location Mathias, W Va.

18 (a) Funeral director H.E. Negus & Brothers
(b) Address Ellicott City Md
Huntington Middletown Md

19 1945 (Date registered) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 19 45 to 6-30 19 45, and that I last saw h alive on 6-30 19 45.

Immediate cause of death	Duration
Coagulation failure	
Due to perforate Stomach	
Due to Lymphosarcoma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/26/45

Major findings of operation: Lymphosarcoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas Parent, Jr. M.D.
Address St Agnes Date signed 6/30/45

VS-150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G30:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. 30:07

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 679 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Belle Grove Rd (25) Brooklyn Md
(If outside city or town limits write RURAL and give town)
(d) Street No. Belle Grove Rd - (20)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Minor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 - 44

8. AGE: Years 1 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace [illegible] Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George R. Minor
13. Birthplace Md

MOTHER
14. Maiden Name Lutie Giles
15. Birthplace Dorsey Md

16 (a) Informant Mr Minor
(b) Address Belle Grove Rd (25)

17 (a) Burial (b) Date thereof July 2 - 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Centerville

18 (a) Funeral director Walter Schulting
(b) Address 2614 Hanover St

(a) 7-1945 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 5.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1945, to 6-30 1945, and that I last saw her alive on 6/30 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Diarrhea	2 da
Due to Heat Exhaustion	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph H Lankester
Address 679 W Johnston Blvd Date signed 7/1/45
M. D.

G30308 BALTIMORE CITY HEALTH DEPARTMENT G30308
CERTIFICATE OF DEATH 1945 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Gill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1880

8. AGE: Years 65 | Months — | Days 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Melchior Metz
13. Birthplace Germany

MOTHER 14. Maiden Name Eva Doch
15. Birthplace Germany

16. (a) Informant Mr Chas Gill
(b) Address 2022 E Preston St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2nd 1945 (month) (day) (year)
(c) Cemetery or crematory New Leatherdale
Location Edmondson Ave

18 (a) Funeral director Leo S. Crook
(b) Address 1701-03 N. Patterson Park Ave

19. (a) JUL 1 1945 (b) Huntington Williams M.D.
(Date filed by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28-45, at 8:15 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 6-21-45 to 6-27-45 and that I last saw h alive on 6-27-45.

Immediate cause of death: Pulmonary Embolism — Duration 1 wk
Due to: Cardiac Decompensation — Duration 1 wk
Due to: Myocarditis — Duration 1 wk
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Foot & Mulliken M.D.
Address Date signed 6-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30309 — BALTIMORE CITY HEALTH DEPARTMENT — G30309

CERTIFICATE OF DEATH 20

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town 801 Cator Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Miriam Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 39 Months Days If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Guyton
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lenore Johnson
15. Birthplace Balto. Md.

16 (a) Informant F. Harold Little
(b) Address 801 Cator Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Taylor Ave

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

19 (a) Filed 1945 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945 to June 29 1945, and that I last saw her alive on June 29 1945.

Immediate cause of death: Uremia
Due to: Tuberculosis of Kidney
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

	Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. D. P. Tinker M.D.
Address Mercy Hosp Date signed 6/29/45 M. D.

G30310 ✓ G30310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Journalist

11. Industry or business "Item" Newspaper

FATHER
12. Name Allan L. Carter
13. Birthplace W. Va.

MOTHER
14. Maiden Name Caroline Corse
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Caroline C. Carter
(b) Address 3902 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Friends
Location Harford Ave. nr 25th

18 (a) Funeral director John J. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945 at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumobacturnia Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-29- at P M.
(b) Where did injury occur? 3902 N. Charles St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Hypostasis - above drug.

23. Signature Howard A. Mueller M.D. Medical Examiner.
Date signed 6-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84a

G30311

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) = 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3226 Leeds St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvina Mc Cuttin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1942

8. AGE: Years 2 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER
12. Name Parke Mc Cuttin
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Manion
15. Birthplace Maryland

16 (a) Informant Mr + Mrs Mc Cuttin
(b) Address 3226 Leeds Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director J. George D. Pechuat
(b) Address 2101 Falsdeuck Ave

19 (a) 1945 (b) Registered by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1945 to 6/30 1945 and that I last saw h[illegible] alive on 6/30 1945.

Immediate cause of death Cardiac failure — Duration

Due to Pulmonary Edema

Due to This child was a Mongolian Idiot.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/29/45

Major findings of operation: Branchial cyst

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Eleanor M.D.

Address St Agnes Hosp. Date signed 6/30/45

G30312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 Valley St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Valley St. (If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Mamie J. Fink

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ##### Charles A. Fink
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 81	---	---	--- hr. --- min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Edward Healy
13. Birthplace Ireland

MOTHER
14. Maiden Name Jennie Armstrong
15. Birthplace England

16 (a) Informant Mrs. Mary Connolly
(b) Address 1225 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery ######## New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director H. A. Means and Son
(b) Address 805 N. Gilmore St. Huntington Williams, Mgr.

19 1945 (Date rec'd by registrar) Registrar

VS. 150

MEDICAL CERTIFICATION

515A

20. DATE OF DEATH June 29 1945, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944, to June 29 1945, and that I last saw h[illegible] alive on June 29 1945.

Immediate cause of death Arteriosclerosis — Duration
Due to hypertension heart disease
Due to
Other Conditions ✓
(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. J. Healy
Address 110 E Northern Date signed 6/30 1945

X

C30313
A40724

BALTIMORE CITY HEALTH DEPARTMENT X ✓
CERTIFICATE OF DEATH 157M

Registered No. C30:313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. VA. (b) County
(c) City or town PARSONS (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Freese

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-45

8. AGE: Years	Months	Days	If less than one day
	4		hr. min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name C. M. Freese
13. Birthplace Illinois

MOTHER
14. Maiden Name Maude Schoonover
15. Birthplace W. Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)
(c) Cemetery or crematory Parsons
Location Parsons, W. Va.

18 (a) Funeral director Frederick S. Dale
(b) Address 1200 W. Lombard St.

19 JUL 2 - 1945 (b) Huntington, West Virginia
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1- 1945 at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11- 1945 to 7-1- 1945 and that I last saw him alive on 7-1- 1945.

Immediate cause of death: Respiratory Obstruction — Duration: 3 hrs
Due to: Cong. Anomaly of Lung
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Romona S. Hall attdg M. D.
Address Hopkins Hospital Date signed 7-1-45

X

G30314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G30314 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MONUMENT & RUTLAND

(c) Hospital or institution:
SINAI HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. Levindale Home
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS RESNICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOW

6 (b) Name of husband or wife Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1851

8. AGE: Years	Months	Days	If less than one day
94			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Michael Resnick
13. Birthplace Russia

MOTHER
14. Maiden Name Rifka Resnick
15. Birthplace Russia

16 (a) Informant Mrs Rose Blum
(b) Address 3432 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUL 2 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1945 to July 2, 1945 and that I last saw him alive on July 2, 1945.

Immediate cause of death PNEUMONIA — Duration

Due to

Due to

Other Conditions PROSTATIC HYPERTROPHY. BLINDNESS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Stanley R Sternbach M. D.

Address 3935 Bowman Ave, Balto Date signed July 2, 45

VS 180

G30315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G30315

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~Balto~~ Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Grace Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Elizabeth Wittemann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Samuel E
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 4 / 1898

8. AGE: Years	Months	Days	If less than one day
47	11	27	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ellis William Bryant
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret O'Connell
15. Birthplace Md.

16 (a) Informant Mr Samuel E. Wittemann
(b) Address 4220 Grace Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John F Kenny Inc & Harris
(b) Address 715 Light St.

19 (a) Date rec'd by JUL 2 - 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1 1945, at 9 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1945, to 7-1 1945 and that I last saw h[illegible] alive on 7-1 1945

Immediate cause of death acute cardiac decompensation — Duration

Due to post operative dehydration

Due to status asthmaticus & pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-21-45

Major findings of operation: Chronic cholecystitis

of autopsy: pulmonary congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. K. Kerr M. D.
Address Fr. Sq. Hosp Date signed 7-1-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30316

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5306 Tilbury Way

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 17

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5306 Tilbury Way

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME CARLTON MANSON SOULE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	214 - 14 - 0359

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Ethel Soule

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1884

8. AGE: Years	Months	Days	If less than one day
61	0	18	hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Asso. Engineer

11. Industry or business J. E. Greiner Co.

FATHER

12. Name John M. Soule

13. Birthplace Mass.

MOTHER

14. Maiden Name Ida W. Bates

15. Birthplace Mass.

16 (a) Informant Mrs. Mary Ethel Soule

(b) Address 5306 Tilbury Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem

Location

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) [illegible] 2 1945 (b) Huntington Wills [illegible] M.E.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1945, at 5:02PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1945 to June 28, 1945 and that I last saw h[illegible] alive on June 28, 1945.

Immediate cause of death	Duration
Cerebral hemmorhage & Paralysis	4 days
Due to Arteriosclerosis	?
Due to	
Other Conditions Cardio vascular disease	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Orville S. Tibbitt M.D.

Address 2220 Harrison Blvd Date signed 6/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G30317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G30317 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymond Parkland
(c) Hospital or institution: West Baltimore Jneral Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1153 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E Zimmerman

3 (b) If veteran, name war: M

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ed A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept-19-1885

8. AGE: Years 59 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Ed A Zimmerman

(b) Address 1153 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md

18 (a) Funeral director Wilhelm Bros Inc

(b) Address 1217 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 2 - 1945 Interment Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to June 30 1945, and that I last saw her alive on June 30 1945.

Immediate cause of death Respiratory failure — Duration

Due to Lymphosarcoma + metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Biopsy Lymphosarcoma

of autopsy: Lymphosarcoma + metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth W Baldwin M. D.

Address West Baltimore Jneral Hosp Date signed 6-30-45

X

G30318 G30318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 10012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3123 Orlando Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Orlando Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS E JENSEN

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-14-0994

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Constance
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1884

8. AGE: Years 60 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business

FATHER 12. Name Nicholas Emil Jensen
13. Birthplace Norway

MOTHER 14. Maiden Name Emma Nilsen
15. Birthplace Norway

16 (a) Informant Constance Jensen
(b) Address 3123 Orlando Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Pilkington Funeral Dir
(b) Address 2219 E Eager St

19 (a) (Date rec'd by registrar) JUL 2 - 1945 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/45 19 . at 3:20 P M

21. I certify that I took charge of the remains described above, held an Inspection Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Phlebothrombosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Davis M.D.
Medical Examiner.
Date signed 7/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30319

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St Agnes Hospital

(c) Hospital or institution: Balto City

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Howard Co

(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)

(d) Street No. Wash. Blvd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Ollie Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1887

8. AGE: Years 58 | Months 4 | Days 14 | If less than one day: hr. min. 10

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Storekeeper

11. Industry or business

FATHER

12. Name James Williams

13. Birthplace Va

MOTHER

14. Maiden Name ?

15. Birthplace Va

16 (a) Informant Ollie Williams

(b) Address Eldridge - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)

(c) Cemetery or crematory Blandford

Location Va

18 (a) Funeral director Edw. S. MacNabb

(b) Address Catonsville Md

19 (a) Date received by Reg. JUL 2 1945 (b) Registrar

Interlineation Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1 1945, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1945 to 7/1 1945 and that I last saw him alive on 7/1 1945.

Immediate cause of death: Complete Heart Block

Due to: Myocardial Heart Disease

Due to:

Other Conditions: Delirium

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Little Rawlins Jr. M. D.

Address Agnes Hosp Date signed 7/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30320 ✓ G30320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. 1 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 849 N. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Gillespie

3 (b) If veteran, name war

3 (c) Social Security Account No. 215709-0164

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of ~~husband~~ or wife: Unknown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/19/1876
8. AGE: Years 70 | Months | Days 11 | If less than one day hr. min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business

FATHER
12. Name Robert Gilespie
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Dungan
15. Birthplace Ohio

16 (a) Informant Eva. Heckerote
(b) Address 1010 Scott st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Ambrose Dietz
(b) Address 1447 Frankhinton rd

19 (a) Date received 1945 Huntington Hill Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed July 1, 1945.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G30:521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G30:521 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 N. Charles Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---1
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 N. Charles St. (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME. De Forrist D. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Stoudt
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 27, 1876

8. AGE: Years	Months	Days	If less than one day
69	1	2	--hr. ---min.

9. Birthplace New York City, N. Y. (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business --------

FATHER
12. Name Nicholas C. Smith
13. Birthplace New York

MOTHER
14. Maiden Name Cornelia Curtis
15. Birthplace New York

16 (a) Informant Mrs. Elizabeth S. Smith
(b) Address 3700 N. Charles Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) (Date received by registrar) (b)

VS 150

JUL 2-1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION chart

20. DATE OF DEATH 6-29 1945 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to 6-29 1945 and that I last saw him alive on 6-22 1945.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis ?
Myocardial Insufficiency
Diabetes mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard E. Legge M. D.
Address 700 Cathedral Date signed 6-30-45

Attested by Howard J. Weschler, M.D.

Melkelden
G30322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G30322 82a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospt.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 121 W. Cross St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beryl Lee McKeldin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 24 1944

8. AGE: Years	Months	Days	If less than one day
	7	6	hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William F. McKeldin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret J. Davis
15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret J. McKeldin
(b) Address 121 W. Cross St.

17 (a) Burial - (b) Date thereof 7-3-45.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John F. Cronan & Son
(b) Address 906-08 W. Pratt St.

JUL 2 - 1945
(Date rec'd by Registrar)

(b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945, to June 30, 1945, and that I last saw her alive on June 29 1945.

Immediate cause of death	Duration
Meningitis	
Due to Influenza Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Nate Clark M. D.

Address Univ Hosp Date signed 6-30-45

X

G30323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G30323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write R (RFD) and name town)
(d) Street No. 1716 Pearsbury Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Junior Cates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-22

8. AGE: Years 23 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Lue Cates

13. Birthplace

MOTHER 14. Maiden Name Novella Holman

15. Birthplace N. C.

16 (a) Informant Lee Cates

(b) Address 1322 Etting

17 (a) Burial (b) Date thereof 7-3-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holmans

Location N. C.

18 (a) Funeral director Sam'l. H. O'Hare & Son

(b) Address 638 N. Gilmor St

19 (a) JUL 2 - 1945 Huntington Wilkins
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945, at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions Subcutaneous emphysema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15-1

(a) Date of injury 6-30-45 at 6 P.M. (b) Where did injury occur? On Gilmor St. 95 feet S. of Baker St.

(c) Did injury occur at home, on farm, industrial place in public place? Public. While at work? No.

(d) Means of injury Operator of Car - Struck a Lamp Post.

23. Signature Thomas J. Mullen M.D.
Medical Examiner

Date signed July 6 1945.

VS 151

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-13 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 26976 AND ENDING WITH 30323 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL